Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: May 24, 2024	
Inspection Number: 2024-1287-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: CVH (No. 4) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Pinecrest (Plantagenet), Plantagenet	
Lead Inspector Maryse Lapensee (000727)	Inspector Digital Signature
Additional Inspector(s) Kelly Boisclair-Buffam (000724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 13, 14, 2024

The following intake(s) were inspected:

- Intake: #00105942/CI #2797-000002-24; Intake: #00108260/CI #2797-000005-24 and Intake: #00114501/CI #2797-000019-24 - related to alleged abuse to resident by another resident.
- Intake: #00108901/CI #2797-000007-24 - related to controlled substance missing/unaccounted.
- Intake: #00109590 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (11) (b)
- Intake: #00110987 - related to a complaint about medication error.

- Intake: #00111511/CI #2797-000011-24 - related to a fall with injury.
- Intake: #00113502/CI #2797-000016-24 and Intake: #00115628 /CI #2797-000023-24 - related to an outbreak.
- Intake: #00114889/CI #2797-000020-24 - related to alleged financial/emotional abuse to resident by a visitor.
- Intake: #00115236/CI #2797-000021-24 - related to a written complaint.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1287-0005 related to FLTCA, 2021, s. 6 (11) (b) inspected by Maryse Lapensee (000727)

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that an intervention set out in a resident's plan of care was complied with as specified in their plan.

Rationale and Summary
In January, 2024, a resident hit a co-resident in the face.

The resident's care plan was reviewed from December, 2023 to March, 2024. On a specific day in March 2024, a specific intervention was added to the resident's care plan with no end date. The intervention was last documentated on a specific day in April 2024.

The Director of Care and the Behavioural Supports Ontario (BSO) Lead confirmed that the intervention should have been initiated following an incident that occurred in January 2024. Both acknowledged that the plan of care had no end date for the intervention and that the monitoring was to be ongoing and not completed on a specific day in April, 2024.

Further interviews with two RPNs confirmed that the intervention had not been

implemented since a specific day in April, 2024, and that both had not been aware of the no end date as written in the resident's care plan.

As such, failing to comply with the specific intervention of the identified resident, potentially increased the risk of the resident's responsive behaviours not being fully analyzed and evaluated, placing other residents at risk for physical aggression.

Sources: Resident's paper and electronic charts , plan of care and progress notes, interviews with DOC, BSO Lead, and RPNs.
[000724]

WRITTEN NOTIFICATION: Policies and Protocols

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that the head to toe and skin assessment protocol for a resident was complied with as per the home's abuse policy.

Rationale and Summary
In January, 2024, an incident of resident to resident alleged physical abuse occurred by a resident towards a co-resident.

A review of the resident's progress notes and head to toe and skin assessment tools in their electronic chart, indicated that no assessments had been completed or documented.

Upon review of the "Process for Nurses - in case of resident to resident abuse" protocol document from the home's Abuse policy, protocol #4 stated that a complete head to toe assessment and a skin assessment and checking of vital signs of any resident who was hit or injured, even if the resident had no visible injuries, were to be documented in the resident's electronic chart.

Interviews with both the Administrator and a RPN, confirmed that vital signs and both head to toe and skin assessments were to be completed after every alleged resident to resident abuse. The RPN acknowledged that this had not been completed for the resident.

As such, failing to complete vital signs and the head to toe and skin assessments for a resident, potentially increased the risk of a missed internal injury.

Sources: Abuse policy / protocol for Nurses, a resident's medical records, interviews with Administrator and a RPN.
[000724]