

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: February 4, 2026
Inspection Number: 2026-1287-0001
Inspection Type: Proactive Compliance Inspection
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 26, 27, 29, 30, 2026 and February 2, 2026.

The following intake(s) were inspected:

- Intake: #00168583 Proactive Compliance Inspection.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards
Pain Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

A resident was noted to have reduced food and fluid intake over the last year, due to a change in the resident's health condition, resulting in a significant weight loss over a period of a month. This resident was observed to be served specified beverages during a meal and snack service. The current resident's plan of care indicated restrictions to a specified nutrient for medical reasons, that included these beverage items. The resident was not reassessed and the plan of care was not revised when the resident's food and fluid restrictions were discontinued.

Sources: Meal and snack service observations; review of the resident's plan of care, progress notes and look back report; interviews with resident, nursing staff members, and a Food Service Manager (FSM).

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 77 (2)

Director of Nursing and Personal Care

s. 77 (2) The Director of Nursing and Personal Care shall be a registered nurse.

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The home did not have a Registered Nurse (RN) in the capacity of Director of Nursing and Personal Care (DON) over a specified period of time. The DON's responsibilities were carried out by a Clinical Consultant, who was a Registered Practical Nurse (RPN).

Sources: Schedule report reviewed; interviews with an RN, a Clinical consultant/RPN, and the Executive Director (ED).

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health (CMOH or MOH) appointed under the Health Protection and Promotion Act were not followed in the home for a resident requiring enhanced precaution requirements with respect to Infection Prevention and Control (IPAC) practices, during an outbreak in the home.

Two staff members did not follow the Personal Protective Equipment (PPE) recommendations for enhanced precautions while providing personal care to a resident, as they did not wear the specified PPE as required.

Sources: A resident's health care records were reviewed and signage at this

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resident's door; observations of staff provision of personal care to a resident;
interviews with these staff members and the home's IPAC lead.