

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

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

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>No de registre</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|-----------------------------------|--|
| May 21, 2021                                   | 2021_768693_0009                              | 004253-21                         | Critical Incident<br>System                        |

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**Licensee/Titulaire de permis**

Board of Management of the District of Kenora  
1220 Valley Drive Kenora ON P9N 2W7

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**Long-Term Care Home/Foyer de soins de longue durée**

Pinecrest (Kenora)  
1220 Valley Drive Kenora ON P9N 2W7

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

MELISSA HAMILTON (693), JULIE KUORIKOSKI (621)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 10 to 13, 2021.**

**The following intake was inspected on during this Critical Incident System (CIS) inspection:**

**-one intake, regarding the improper care of a resident.**

**Follow Up inspection #2021\_768693\_010 was conducted concurrently with this CIS inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Personal Support Workers (PSW), and a Housekeeper.**

**The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.**

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

**Falls Prevention**

**Infection Prevention and Control**

**Nutrition and Hydration**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

|   |  |
|---|--|
| <p>Legend</p> <p>WN – Written Notification<br/>VPC – Voluntary Plan of Correction<br/>DR – Director Referral<br/>CO – Compliance Order<br/>WAO – Work and Activity Order</p>  | <p>Légende</p> <p>WN – Avis écrit<br/>VPC – Plan de redressement volontaire<br/>DR – Aiguillage au directeur<br/>CO – Ordre de conformité<br/>WAO – Ordres : travaux et activités</p>  |
| <p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee was failed to ensure that a resident was treated with courtesy and their dignity was respected.

A Critical Incident System (CIS) report was submitted to the Director related to the improper treatment of a resident. A PSW student observed a resident and an RN engaged in a conversation. The PSW student indicated that the resident became upset and that the RN pushed the resident's ambulation device, out of the resident's reach, at which time the resident began to cry. The resident's care plan indicated the resident needed the device to ambulate safely.

During separate interviews with the DOC and an RN, they indicated that the resident was not treated with courtesy and respect by the RN.

Sources: CIS report; the home's investigation file; a resident's care plan; "Zero Tolerance of Abuse and/or Neglect, ADM 450" policy, last revised December 2020; "Falls Prevention and Management Program, NUR 145" policy, last revised March, 2021; and interviews with an RN, the DOC, and other relevant staff members. [s. 3. (1) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.***

**Issued on this 25th day of May, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**