Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2021	2020_831211_0019	012622-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Pinecrest (Plantagenet)
101 Parent Street P.O. Box 250 Plantagenet ON K0B 1L0

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

JOELLE TAILLEFER (211)

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): December 17, 2020, January 8 and 11, 2021.

CIS log #012622-20: related to fall and hospitalization and change of condition.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Office Manager, a Registered Nurses (RN), a Resident Assessment Instruments and Minimum Data Set Coordinator (RAI Coordinator/RPN) a Registered Practical Nurse (RPN), several Personal Support Workers (PSWs), Physiotherapy Assistant, and a resident.

In addition, during the course of the inspection, the inspector reviewed several resident health care records including Fall sheets, Care Plans, Falls- Clinical Monitoring Records, Risk Management/Fall, Patient Attendance Records, Policies #RC-15-01-01 "Falls Prevention and Management Program" and RC-25-01-38 "Neurological Signs/Head Injury Routine", and observed the provision of resident care and services and observed resident mobility aides.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #001 that sets out clear direction to staff and others who provide direct care to the resident's mobility.

Resident #001 sustained an injury after a fall. Resident's plan of care, indicated that the resident was independent using a walker. Six months later, the resident's care plan, indicated that the resident required total assistance with a different type of device and to use the wheelchair at all times. However, the same care plan indicated to remind the resident to use the walker at all times. Resident Assessment Instruments (RAI) Coordinator stated that they forgot to remove the comment pertaining the use of the walker.

The licensee has failed to ensure that resident #001's care plan sets out clear direction to staff and others related to the resident's mobility.

Sources: Resident #001's care plans and progress notes, interview with the Resident Assessment Instrument (RAI) Coordinator #105. [s. 6. (1) (c)]

Issued on this 10th day of February, 2021

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

Original report signed by the inspector.