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

Original Public Report

Report Issue Date: September 6, 2023

Inspection Number: 2023-1287-0003

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	**Inspector Digital Signature**
Maryse Lapensee (000727)	Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2023.09.06 14:28:35 -04'00'

Additional Inspector(s)
Julienne NgoNloga (502)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29, 30, 31, 2023 and September 1, 2023

The following intake(s) were inspected:
Critical incident (CI):
- Intake: #00085123 - CI#2797-000014-23 - Injury of resident with unknown cause.
- Intake: #00091611 - CI#2797-000023-23 - Missing resident for less than three hours
- Intake: #00095468 - CI#2797-000026-23 - Allegation of resident to resident physical abuse

Complaint: Intake: #00090079 - related to multiple care concerns

Follow-up: Intake: #00091243 - related to staff training

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1287-0002 related to FLTCA, 2021, s. 24 (1) inspected by Julienne NgoNloga (502)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards

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 (10) (b)

The licensee failed to ensure that a resident was reassessed and their plan of care revised at least every six months and at any other time when the resident's care needs change.

Rationale and Summary

A resident's plan of care stated they participated in bed mobility with the assistance of one to two staff members.

Two Personal Support Worker (PSW) acknowledged that the resident required two staff members for their bed mobility. PSW confirmed that the resident's bed mobility had changed more than six months ago.

A Registered Practical Nurse (RPN) confirmed that the resident's plan of care for bed mobility was not revised to reflect their needs.

As such, a resident was at risk of improper care as their care needs changed and they were not reassessed.

Source: Resident Health records, Interview with PSW and RPN
[000727]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, must be kept closed and locked, was complied with.

Rationale and Summary
In July 2023, the side door mag lock was released by a power outage. The door remained unlocked when the power was restored. A resident exited the home and was found later in the parking lot.

The Executive Director (ED) acknowledged that the side door leading outside of the home was not locked when the power was restored following a power outage allowing the resident to exit the home.

By not securing the door leading to the outside of the home, a resident went missing for ten minutes.

Sources: Resident's progress note. Interview with the ED.
[502]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii.

The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or

doors that residents do not have access to, must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

Rationale and Summary
The side door leading to the outside of the home remained unlocked when the power was restored following a power outage in July 2023. The staff were not alerted when a resident left the building using the same door.

The ED stated that the side doors leading to the outside of the home were disconnected to an audible door alarm when the home upgraded their call bell system and have not been reconnected to the audible door alarm at the time of this inspection.

By not connecting the doors leading to outside of the home to an audible door alarm, a resident went missing for ten minutes.

Sources: Resident's progress note. Interview with the ED
[502]