

### **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: March 28, 2025

**Inspection Number**: 2025-1287-0002

**Inspection Type:** 

Complaint

**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): March 18, 19, 20, 21, 25, 26, 27, 28, 2025

The inspection occurred offsite on the following date(s): March 24, 2025 The following intake(s) were inspected:

 Intake: #00141604 - Complaint intake related to physical abuse resident to resident

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

Infection Prevention and Control Responsive Behaviours Prevention of Abuse and Neglect

# **INSPECTION RESULTS**



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## WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The Licensee has failed to ensure that licensee's falls prevention and management program was followed, specifically that a head injury routine (HIR) was completed on a resident as per policy requirement.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, and that it must be complied with.

As per the licensee's Falls Prevention and Management Policy, a HIR was to be initiated for a resident that sustained a potential head injury. A resident had a witnessed fall and required monitoring. The HIR was not completed as per schedule and monitoring was not completed on one shift post fall.

Sources: Falls Prevention and Management, RFC 07-01, created August 2024 and interview with Director Of Care (DOC).

**WRITTEN NOTIFICATION: Responsive behaviours** 



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

Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)

Responsive behaviours

s. 58 (3) The licensee shall ensure that,

(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The licensee has failed to ensure that written approaches such as screening tools were implemented.

The Dementia Observation System (DOC) documentation is used as a screening tool when resident are exhibiting responsive behaviors.

A resident exhibited responsive behaviors and DOS was initiated. It was noted that the DOS documentation was not completed, as there were periods of hours, that the staff did not document as per requirements.

Sources: DOS tools and interview with the DOC.

## **WRITTEN NOTIFICATION: Administration of drugs**

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s.



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140 (2).

The licensee has failed to ensure that a medication was administered to a resident, in accordance with the directions for the use of specified by the physician.

On an identified date in 2024, a resident's medication daily dosage was increased. The pharmacy sent the wrong dosage which was administered to the resident for a specific period.

Sources: Medication Administration Record, physician order, email form pharmacy and interview with the DOC.