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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 23, 2020 | 2020_770178_0019 | 021911-20 | Critical Incident System |

### Licensee/Titulaire de permis

North Renfrew Long-Term Care Services Inc.
47 Ridge Rd Deep River ON K0J 1P0

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

North Renfrew Long-Term Care Services
47 Ridge Road P.O. Box 1988 Deep River ON K0J 1P0

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

SUSAN LUI (178)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): December 9, 10, 15, 2020.**

**The following intake was completed in this Critical Incident System (CIS) Inspection:**
**Log #021911-20/CIS #3036-000003-20 was related to alleged neglect.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Registered Nurse (RN), a Registered Practical Nurse (RPN), the Manager of Resident Services, family of a resident, and a resident.**

**During the course of the inspection the inspector observed residents and resident home areas, resident and staff interactions, and reviewed clinical health records, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Prevention of Abuse, Neglect and Retaliation**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>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 |
| 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).<br><br>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.<br><br>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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident was to wear a specific incontinence product during the night. During one night, a PSW inadvertently changed the resident into the incontinence product meant for the resident during the day. In the morning the resident and their bedding was saturated with urine.

Sources:
A resident's clinical health record; interviews with a PSW and the Manager of Resident Services. [s. 6. (7)]

2. A resident's plan of care indicated that two staff members were needed to provide total assistance with the resident's bed mobility. A PSW sometimes pulled the resident up in the bed independently when a second staff member was not readily available to assist.

Sources:
A resident's clinical health record, interviews with a PSW and the Manager of Resident Services. [s. 6. (7)]

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**Issued on this 31st day of December, 2020**

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

**Original report signed by the inspector.**