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
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Original Public Report

Report Issue Date: July 2, 2024	
Inspection Number: 2024-1517-0001	
Inspection Type: Complaint Critical Incident	
Licensee: North Renfrew Long-Term Care Services Inc.	
Long Term Care Home and City: North Renfrew Long-Term Care Services, Deep River	
Lead Inspector Ashley Martin (000728)	Inspector Digital Signature
Additional Inspector(s) Karen Buness (720483)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25, 26, 27, 2024

The following intake(s) were inspected:

- Intake: #00095192 - A missing or unaccounted for controlled substance
- Intake #00119941- Complaint related to meal service

The following Inspection Protocols were used during this inspection:

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Respond

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Sources: Resident Council Meeting minutes, interview with Nutrition and Environmental Services Lead

[720483]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The Licensee has failed to ensure that documentation of immediate actions taken to maintain the resident's health was completed following a medication incident of a missing controlled substance. Specifically, a pain assessment was not completed following a missing narcotic patch for a resident on a specific date.

Sources: Resident record review and an interview with Resident Care Services Manager

[000728]