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 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 1st 2023	
Inspection Number: 2023-1517-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: North Renfrew Long-Term Care Services Inc.	
Long Term Care Home and City: North Renfrew Long-Term Care Services, Deep River	
Lead Inspector Erica McFadyen (740804)	**Inspector Digital Signature** Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2023.06.01 15:28:14 -04'00'
Additional Inspector(s) Carrie Deline (740788)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15th-18th, 2023

The following intake(s) were inspected:

- Intakes: #00017165 - IL-08758-OT; #00017469 - IL-08913-OT;#00019232 - IL-09607-OT; 00015214 - IL-08001-OT and #00020151 - IL-09987-OT Complaint regarding the delivery of dietary services within the long-term care home and alleged staff to resident abuse
- Intake: #00019424 - 3036-000001-23 resident fall resulting in injury and significant change in status
- Intake: #00085447 - 3036-000002-23 -resident fall resulting in injury and significant change in status

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

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 (1) (c)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

During an observation of the kitchen on May 16th, 2023 Inspector #740804 asked the cook for a copy of the resident diet care plans that are followed by the kitchen staff. During review of this book it was noted that the dietary plan of care for resident #003 indicated a specified diet.

Review of the nutrition care plan in Point Click Care for resident #003 indicated a different specified diet. Review of the resident profile for resident #003 in Point Click Care stated a diet texture different than either previously noted diet texture.

In an interview with Dietary Aide #006 it was stated that the care plan in the kitchen and the diet texture on the resident profile for resident #003 were incorrect. In an interview with Dietary and Environmental Services Leader #108 it was stated there was a discrepancy between the three diet textures listed and that the dietary plan of care for resident #003 was not clear.

Unclear direction within the dietary care plan puts residents at risk for not receiving the correct diet texture.

Sources
Observations of the kitchen, review of the clinical record for resident #003, interviews with Dietary Aide

#006 and Dietary and Environmental Services Leader #108

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