

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Sudbury Service Area Office**

159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Original Public Report

**Report Issue Date:** February 7, 2023

**Inspection Number:** 2023-1529-0001

**Inspection Type:**

Complaint  
Critical Incident System

**Licensee:** Board of Management for the District of Nipissing West

**Long Term Care Home and City:** Au Chateau, Sturgeon Falls

**Lead Inspector**

Lauren Tenhunen (196)

**Inspector Digital Signature**

## INSPECTION SUMMARY

The Inspection occurred on the following dates:

- January 9-13, onsite and January 16, 2023, offsite.

The following intakes were inspected:

- One intake regarding a resident fall with injury;
- One intake regarding resident to resident sexual abuse;
- One intake regarding neglect of residents by staff; and
- Two intakes regarding a complaint about Residents' Bill of Rights.

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

Infection Prevention and Control  
Responsive Behaviours  
Prevention of Abuse and Neglect  
Residents' Rights and Choices  
Falls Prevention and Management

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## 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 (5)

The licensee has failed to ensure that the resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of a resident's plan of care.

**Rationale and Summary:**

A specialized device was initiated and was to be used during an activity of daily living for a resident.

The care plan indicated the involvement of the substitute decision maker (SDM) and the progress notes identified the use of the specialized device and when it was to be used.

Home's policy re: "Resident Care Plan" - Index C-010, read, "Resident care plan is a set of directives determined to provide the care each resident needs and wants in consultation with other members of the professional care team, the resident/SDM and family members"

The DOC confirmed that the resident's SDM was not made aware of the change to the resident's activity of daily living until a few days afterward; the policy for care planning was not followed; and the SDM wasn't notified in a timely manner when there was the change to the activity of daily living.

**Sources:** Interviews with a Registered Nurse (RN), Director of Care (DOC); review of policy titled, "Resident Care Plan" - Index C-010, Point Click Care (PCC) progress notes and care plan.

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