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

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

Original Public Report

Report Issue Date: May 10, 2023	
Inspection Number: 2023-1529-0002	
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 Amanda Belanger (736)	**Inspector Digital Signature** Amanda Belanger Digitally signed by Amanda Belanger Date: 2023.05.18 08:15:51 -04'00'
Additional Inspector(s) Charlotte Scott (000695)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17-20, 2023
The inspection occurred offsite on the following date(s): April 24, 2023

The following intake(s) were inspected:

- one intake related to a complaint received by the Director regarding resident care needs;
- one intake related to a report submitted to the Director regarding improper care of a resident; and,
- one intake related to a report and complaint received by the Director regarding an injury to a resident that resulted in a significant change in status.

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

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

Safe and Secure Home
Residents' Rights and Choices
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Windows in the Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that windows that open to the outdoors and which residents had access to, had screens in place and, opened no more than 15 centimeters (cm).

Summary and Rationale
The Inspector observed open windows in the resident bedrooms, without screens present. Upon further observation, it was noted that the window openings appeared larger than 15 cm.

The maintenance team confirmed that the windows did not have screens present, and that the windows opened more than the 15 cm allowed.

There was moderate risk to the residents, as the windows opened greater than 15 cm.

Sources: Inspector observations of windows; interview with Maintenance Aid, and Maintenance Supervisor.

[736]

WRITTEN NOTIFICATION: Safe Lifts and Transfers

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that the Personal Support Worker (PSW) used safe transferring techniques when assisting the resident.

Summary and Rationale
The PSW did not use techniques as per the "Safe Use of Lifting Devices Preparing for a Lift Policy", as they were required to have two staff present to ensure the resident's safety during the lift and transfer, however, did not have the second staff member present. The PSW indicated they did not follow the home's policy requiring two staff to complete a mechanical lift and transfer.

There was moderate risk to the resident by the PSW not providing a safe lift and transfer.

Sources: Progress notes, and care plan for the resident; employee file and training records for the PSW; the home's investigation notes; license policy titled "Safe Use of Lifting Devices Preparing for a Lift" last revised 2011, issued June 2005; and interviews with the PSW, the Director of Care, and other relevant staff.

[000695]

WRITTEN NOTIFICATION: Individualized Menu Cycles

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (6)

The licensee has failed to ensure that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

Summary and Rationale
The resident's plan of care, as well as admission notes, indicated the resident chose to follow a specified diet. A review of the home's menu cycle did not include an individualized menu for the resident with appropriate substitutions.

The Dietary Manager indicated that the home was still in the process of developing a special menu for the resident, despite the resident having a dietary need that could not be met through the home's menu cycle.

The Dietitian confirmed that there should have been an individualized menu based on the resident's known dietary restrictions.

There was moderate risk to the resident's quality of life, and nutritional status, as a result of the resident's not having an individualized menu to meet their needs.

Sources: Inspector observations; the resident's progress notes, care plan, and admission notes; home's menu cycle; licensee policy titled "Therapeutic Intervention and Diet Terminology" #05-01-02; and, interviews with the Dietary Manager and other staff.

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