Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

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

Original Public Report

Report Issue Date: June 22, 2023	
Inspection Number: 2023-1529-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Board of Management for the District of Nipissing West	
Long Term Care Home and City: Au Chateau, Sturgeon Falls	
Lead Inspector Jennifer Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2023.07.05 12:57:27 -04'00'
Additional Inspector(s) Tracy Muchmaker (690)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-31, 2023 and June 1-2, 5-6, 2023.

The following intake(s) were inspected:

- An Intake related to a proactive compliance inspection.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to ensure that interventions were implemented to mitigate and manage nutritional risks related to a resident's fluid consistency requirements.

Rationale and Summary
A resident was to receive a specified fluid consistency according to their diet orders, and care plan. During a meal observation, the Inspector observed incorrect fluid consistency was served to the resident.

A Personal Support Worker (PSW), the Food Service Manager (FSM), and the Registered Dietitian (RD) all confirmed that the resident received the incorrect fluids as per their current diet order.

There was a moderate risk of providing the incorrect fluid consistency as the resident had previously been choking on it.

Sources: Observation of the resident during a meal ; the resident's diet order and care plan; interviews with staff.
[690]

WRITTEN NOTIFICATION: Menu planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)

The licensee has failed to ensure that a written record was kept of the evaluation of the home's menu cycle, that included the date of the evaluation, the names of the persons who participated in the evaluation, and a summary of any changes made, along with a date that the changes were implemented.

Rationale and Summary
The Inspector requested a copy of the written record of the evaluation of the menu cycle that was in place at the time of the inspection. The RD provided the inspector with a copy of the menu cycle that was signed by the previous RD at the home. The RD, FSM, and Administrator confirmed that there were no other documents related to the evaluation of the menu cycle.

The risk of not having a written record of the menu cycle evaluation posed a minimal risk to the residents.

Sources: Interviews with the FSM, RD, and the Administrator.
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