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**
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# Original Public Report

**Report Issue Date:** February 2, 2024

**Inspection Number:** 2023-1529-0006

**Inspection Type:**
Complaint
Critical Incident

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

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

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Samantha Fabiilli (000701) | Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2024.03.05 15:23:17 -05'00' |

**Additional Inspector(s)**
Chad Camps (609)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11 to 15, 2023
The inspection occurred offsite on the following date(s): December 18 to 19, 2023

The following intake(s) were completed during this inspection:

- One intake related to outbreaks.
- Three intakes related to abuse.
- One intake related to restraints.

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

Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Restraints/Personal Assistance Services Devices (PASD) Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, that resulted in harm or a risk of harm to a resident, immediately reported the suspicion and the information upon which it is based to the Director.

**1.**
**Rationale and Summary**

The Director of Care (DOC) received an email after hours from staff which indicated an incident towards a resident, by a staff member.

Despite the home's policy which required an immediate report of the incident to the Director, the DOC admitted that they did not inform the Director until the next day, when they returned to the home.

The DOC's failure to immediately report the incident and the information upon which it was based to the Director presented no risk to the resident as the DOC had ensured resident safety upon becoming aware of the incident.

**Sources:** A policy from the home; A Critical Incident (CI) report; and an interview with the DOC. [609]

**2.**
**Rationale and Summary**

A CI report identified an incident occurred on a specified day, however it was not reported until three days later, as well no after-hours report was identified.

Late reporting of the critical incident posed a low risk to the residents.

**Sources:** A CI report; Email from staff; Interview with the DOC. [000701]

**3.**
**Rationale and Summary**

During a meal service on a specified day, two staff members witnessed an incident involving a staff member.

Despite the home's policy which required an immediate report of the incident, a

staff member failed to make a report to the Director.

The home's failure to ensure that staff immediately reported allegations of abuse to the Director presented low risk to the resident.

**Sources:** Policies from the home; A CI report; and interviews with staff and the DOC. [609]

## WRITTEN NOTIFICATION: When PASD may be used

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 36 (3)**
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident only if the use of the PASD was included in the resident's plan of care.

**Rationale and Summary**

On two occasions, the Inspector observed that a resident was utilizing a PASD.

Despite the home's policy which required the PASD be included in the resident's plan of care, there was no mention of the PASD in the resident's plan of care.

The home's failure to include PASD in the resident's plan of care presented

moderate risk to the resident.

**Sources:** A policy of the home; Inspector's observations; A residents care plan and assessments; Interviews with staff and the DOC. [609]

## WRITTEN NOTIFICATION: Minimizing of Restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 38 (a)**
Prohibited devices that limit movement
s. 38. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or

The licensee has failed to ensure that no device provided for in the regulations was used on a resident to restrain them.

**Rationale and Summary**
During a meal service, a staff member utilized a prohibited device on a resident.

A staff member verified that this incident had occurred.

The home's failure to ensure that a prohibited device was not used with a resident presented risk to the resident.

**Sources:** A policy of the home; A CI report; Documents from the home; and Interviews with staff. [609]

## WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.**
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the door to a clean utility room was kept closed and locked when not being supervised by staff.

**Rationale and Summary**

The Inspector observed a clean utility room's door unlocked and unattended.

The following day, the clean utility room's door continued to be unlocked and unattended.

The Director of Care (DOC) verified that the door should be locked when not attended by staff.

The home's failure to ensure that a clean utility room's door was locked when not attended by staff presented risk to residents potentially entering the room unsupervised.

**Sources:** Inspector observations; and interviews with staff and the DOC. [609]

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.**
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that written strategies, including techniques and interventions, were developed to meet the needs of a resident.

**Rationale and Summary:**
In review of a resident's current care plan, it identified that one of their sections was not revised to reflect the resident's individual specifications.

The DOC indicated that this section of the resident's care plan should be specified as much as possible and indicated that it should be updated.

Not revising the resident's care plan with the specific focus, goals and interventions, posed a low risk to the resident.

**Sources:** A resident's care plan; Interview with the DOC.
[000701]

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented; specifically, the licensee has failed to ensure that the staff had access to Alcohol-Based Hand Rub (ABHR) that was 70-90% alcohol concentration and provided hand hygiene to residents before meals.

a)
**Rationale and Summary:**
According to 10.1 of the IPAC Standard for Long Term Care (LTC) Homes, revised September 2023, the licensee was required to ensure that staff providing direct resident care had immediate access to ABHR that contained 70-90% alcohol concentration.

Observations identified multiple units that had hand sanitizer which contained 60% ethyl alcohol. The homes Hand Hygiene program indicated that the home is to have 70% ABHR strategically placed throughout the home.

A staff member confirmed the home is to follow the use of 70% hand sanitizers and was not aware the specified hand sanitizer in use was only 60% alcohol concentration.

Having hand sanitizers available that were 60% alcohol concentration posed a low

risk as the home also had wall sanitizer stations that contained hand sanitizer with 70% ethyl alcohol.

**Sources:** Observations; Policies of the home; Interview with a staff member. [000701]

b)
**Rationale and Summary:**

According to 10.2 of the IPAC Standard for Long Term Care (LTC) Homes, revised September 2023, the licensee was required to ensure that their hand hygiene program provided hand care support for residents, specifically in assisting residents to perform hand hygiene before meals.

The homes Hand Hygiene program indicated that residents are to be helped to clean their hands before meals.

An observation identified staff serving residents their lunch meals, however the observation did not identify staff offering hand hygiene to residents.

A staff member indicated that residents were provided hand hygiene in their rooms prior to lunch. The DOC confirmed that hand hygiene should be provided when the residents enter the dining room.

Not offering hand hygiene to the residents prior to meals posed a low risk to residents.

**Sources:** A policy of the home; An Inspector Observation; Interviews with staff and

the DOC.
[000701]