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: July 11, 2024

Inspection Number: 2024-1529-0001

Inspection Type:
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**
Sylvie Byrnes (627)	Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2024.07.11 13:26:23 -04'00'

Additional Inspector(s)
Lisa Moore (613)
Arash Pouralborz (000837)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-27, 2024.

The following intake(s) were inspected:

- Intake #00108729 related to resident to resident abuse;
- Intake #00111884 related to neglect of a resident;
- Intake #00112137 related to an Influenza A outbreak; and,
- Intake #00113918 related to an unexpected death of a resident.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, twice a week by the method of their choice.

Rationale and Summary: During a specified period, a resident was not provided with two weekly baths; the baths were not rescheduled. The DOC verified that residents were expected to be bathed, twice a week by the method of their choice and stated staff failed to communicate and follow up with other staff to ensure that the resident received two weekly baths by the method of their choice.

The risk and impact was low to the resident as they had received daily morning and bedtime care.

Sources: CI report; Investigation file; Point of Care (POC) bathing documentation; and an Interview with DOC. [613]