

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

Public Report

Report Issue Date: August 7, 2025

Inspection Number: 2025-1529-0005

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 21-25, and July 28, 2025
The inspection occurred offsite on the following date(s): July 28, 2025

The following intake(s) were inspected:

- Two Intakes: related to Fall of resident resulting in injury.
- One Intake: related to Improper/incompetent care of resident.
- One Intake :Complainant related to care concerns of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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 (1) (c)

Plan of care

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s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that when a resident returned from hospital, that clear directions were provided in the plan of care.

Sources: A resident's medical record; interviews with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the falls program to provide a falls risk assessment for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program must, at a minimum, provide strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's "Falls Prevention and Management" policy that stated that staff were to ensure that a specified assessment was to be done at a minimum, annually.

Sources: Review of the Critical Incident (CI); the home's policy; a resident's medical record; and Interviews with staff.

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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure a resident received a skin assessment by a Registered Nurse (RN) upon return from hospital.

Specifically, when a resident returned from hospital an assessment using a clinically indicated assessment tool was not immediately completed.

Sources: A resident's medical records; Interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (1) 1.

Continence care and bowel management

s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:

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1. Treatments and interventions to promote continence.

The licensee has failed to ensure that the home's continence program, which includes the home's policy was complied with.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for continence care and bowel management, and ensure they were complied with.

Specifically, when a resident returned from the hospital the home's policy was not complied with related to assessments.

Sources: A resident's medical records; the home's policy Interviews with staff; the home's policy.

COMPLIANCE ORDER CO #001 Requirements relating to restraining by a physical device

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 119 (7)

Requirements relating to restraining by a physical device

s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

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The licensee shall:

- a) Conduct a documented review of the identified resident's plan of care to ensure that all of the requirements of O. Reg. 246/22, s. 119 (7) are included in their plan of care.
- b) Develop and implement an auditing process to ensure that the required restraint monitoring and documentation has been completed for the identified resident. The audits must be complete at a minimum twice weekly for a period of four weeks. A record of these audits is to be maintained including the date and time of the audit, observations made, any actions taken based on the audits, and the person responsible for the audits and action plan.

Grounds

The licensee has failed to ensure that the requirements associated with the use of a physical device to restrain a resident under section 35 of the act was documented. Documentation requirements included alternatives to restraints considered, an order that provided directions for use, assessments and monitoring of the response to the restraint, and the names of the persons applying and releasing the device.

Sources: A resident's medical record; interviews with staff; the home's policy

This order must be complied with by September 26, 2025

COMPLIANCE ORDER CO #002 Skin and wound care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iv) is reassessed at least weekly by an authorized person described in subsection

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(2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- a) Conduct a documented review of the home's skin and wound program.
- b) Develop and implement an action plan for any required changes to the skin and wound program.
- c) Provide education to all registered staff regarding the changes to the skin and wound program. Maintain a record of the education provided, the names of staff who were in attendance, the dates of the education provided, and the name of the individual responsible for providing the education.

Grounds

The licensee has failed to ensure that when identified residents developed areas of impaired skin, that they were assessed and treated immediately, and reassessed at least weekly using a clinically appropriate assessment tool.

Sources: Two resident's medical records; Interviews with staff; the home's policy.

This order must be complied with by September 26, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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

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