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

Public Report

Report Issue Date: October 6, 2025
Inspection Number: 2025-1529-0006
Inspection Type:
Complaint
Critical Incident
Follow up

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): September 22-26, 2025

The following intake(s) were inspected:
- One intake, a Critical Incident (CI) related to an allegation of resident to resident abuse;
- One intake, a follow up to CO #003 from 2025-1529-0003, for O. Reg. 246/22 - s. 102 (9) (a) - Infection prevention and control program;
- One intake, a follow-up to CO #002 from 2025-1529-0003, for O. Reg. 246/22 - s. 79 (1) 4. s. 102 (9) (a) - Dining and snack services;
- One intake, a follow up to CO #001 from 2025-1529-0003 for FLTCA, 2021 - s. 24 (1) - Duty to protect; and,
- One intake, a complaint related to the care of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2025-1529-0003 related to O. Reg. 246/22, s. 102 (9) (a)
Order #002 from Inspection #2025-1529-0003 related to O. Reg. 246/22, s. 79 (1) 4.
Order #001 from Inspection #2025-1529-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services

Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care was provided to a resident as specified in the plan of care.

A resident's care plan identified that they required a certain level of assistance to perform activities of daily living (ADLs); however, staff provided a different level of assistance with ADLs.

Sources: A resident's care plan; the home's investigation file; interviews with a Personal Support Worker (PSW), and the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment

and that the plan is implemented;

The licensee has failed to ensure that a resident's individualized plan to manage continence was implemented.

A resident required the assistance of staff to manage continence, but the resident didn't always receive the required assistance.

Sources: A resident's care plan; the home's investigation file; interviews with PSW staff and the ADOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies identified to respond to responsive behaviours were implemented for a resident.

A resident had strategies in place to address identified responsive behaviours. On one occasion, the resident was displaying the responsive behaviours, staff did not implement the appropriate strategies, and were unable to complete care at that time.

Sources: A resident's care plan; the home's investigation file; interviews with PSW staff, and the DOC.

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