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

Sudbury Service Area Office
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: 1-(800)-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date: December 8, 2022	
Inspection Number: 2022-1479-0001	
Inspection Type: Critical Incident System	
Licensee: The West Nipissing General Hospital	
Long Term Care Home and City: The West Nipissing General Hospital, Sturgeon Falls	
Lead Inspector Steven Naccarato (744)	**Inspector Digital Signature** Steven C Naccarato Digitally signed by Steven C Naccarato Date: 2022.12.11 21:59:35 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-23, 2022.

The following intake was inspected:

- An intake related to alleged abuse.

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

Prevention of Abuse and Neglect
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident was treated with courtesy and respect.

Rationale and Summary

A staff member treated a resident in a disrespectful manner.

The Long-term Care Clinical Manager confirmed that the disrespectful behaviour was unacceptable and is not tolerated at the home.

There was low impact to the resident as they did not recall the incident.

Sources: The Critical Incident (CI); the home's internal investigation; interview with the Long-term Care Clinical Manager, and other staff.
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WRITTEN NOTIFICATION: Protection from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

The licensee has failed to ensure that a resident was not restrained for the convenience of staff.

Rationale and Summary

A staff member restrained a resident for their convenience.

In an interview with the Administrator, they indicated that restraining a resident for convenience was unacceptable.

There was low impact to the resident as they did not recall the incident.

Sources: The Critical Incident (CI); the home's internal investigation; interview with the Long-term Care Clinical Manager, and other staff.

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