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: December 5, 2023

Inspection Number: 2023-1479-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: The West Nipissing General Hospital

Long Term Care Home and City: The West Nipissing General Hospital, Sturgeon Falls

Lead Inspector	**Inspector Digital Signature**
Jennifer Lauricella (542)	Jennifer Lauricella Digitally signed by Jennifer Lauricella Date: 2023.12.05 15:01:20 -05'00'

Additional Inspector(s)
Shannon Russell (692)
Yannis Wong (000707)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23, 24, 25, 26, 2023

The following intake(s) were inspected:

- Intake: #00099404 - PCI Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Registered dietitian

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (1)

The licensee has failed to ensure that there is at least one registered dietitian for the home.

Rationale and Summary
The home has been without a Registered Dietitian (RD) since July 2023. It was identified that 4 residents were assessed at high nutritional risk and had not been reassessed for 3 months.

The home's policy titled "Dietitian Guidelines" indicated that all residents shall be followed by the RD quarterly, and any resident considered at high nutritional risk shall be followed by the RD monthly or more frequently as required. The Food Service Manager (FSM) confirmed that residents had not received a nutrition assessment by an RD since July 2023 and the policy was not followed.

Failure to have an RD in the home could delay assessment and interventions for residents at high nutritional risk.

Sources: Clinical records for residents for 4 residents; "Dietitian Guidelines" policy, approved 2022-01-11; interview with FSM.

[000707]

WRITTEN NOTIFICATION: Plan of care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a residents plan of care included clear directions about their nutritional care risks.

Rationale and Summary
Specifically, there were inconsistencies in the resident's plan of care about their nutritional care risks.

The resident was last assessed by the Registered Dietitian (RD) on a specific day in June, 2023 at high nutritional risk for specific health reasons. The FSM and a Registered Practical Nurse (RPN) completed a nutritional risk assessment for the

resident and identified them at medium nutritional risk on a specific day in October, 2023. The resident's care plan did not include any risks related to nutritional care.

The home's "Dietitian Guidelines" policy indicated that the RD should update the resident's care plan. The FSM confirmed the resident's nutritional care risks should have been included in the care plan. They also confirmed that the resident was at high nutritional risk as per the RD's most recent assessment.

Failure to ensure there were clear directions in the resident's plan of care about nutritional care risks can affect communication with direct care staff.

Sources: Resident's clinical records; "Dietitian Guidelines" policy, approved 2022-01-11; interview with FSM.

[000707]

WRITTEN NOTIFICATION: Powers of the Residents' Council

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

The licensee has failed to ensure that when the Residents' Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council (RC) in writing.

A review of the RC meeting minutes and an interview with the RCs' assistant indicated that the home had not been responding to the Council in writing regarding their concerns or recommendations.

There was potential risk to residents when the home failed to address their concerns or recommendations in writing.

Sources: RC meeting minutes and interview with the RCs' assistant.

[542]

WRITTEN NOTIFICATION: Menu planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)

The licensee has failed to ensure that a written record was kept of the home's menu cycle evaluation under clause (2) (b) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented.

Rationale and Summary
The Inspector requested a copy of the written record of the evaluation of the menu cycle that was in place at the time of the inspection. The FSM stated the current menu cycle was evaluated by the previous Registered Dietitian (RD) and previous FSM but was unable to produce a copy of the written record.

Failure to retain a written record of the menu cycle evaluation could pose risk to residents as there was no documentation the menu was assessed for nutritional adequacy.

Sources: Interview with the FSM.

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