

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**Sudbury Service Area Office
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2021	2021_894684_0003	011350-21, 012343- 21, 012367-21	Critical Incident System

Licensee/Titulaire de permisAlgonquin Nursing Home of Mattawa
207 Turcotte Park Road P.O. Box 270 Mattawa ON P0H 1V0**Long-Term Care Home/Foyer de soins de longue durée**Algonquin Nursing Home
207 Turcotte Park Road P.O. Box 270 Mattawa ON P0H 1V0**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 18-21, 2021

The following intakes were inspected on during this Critical Incident inspection: Two Critical Incident reports that were submitted to the Director regarding allegations of resident to resident physical abuse; and, One Critical Incident report that was submitted to the Director regarding an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers (Hskg) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that alleged abuse of a resident by a staff member was immediately investigated.

Review of the home's file regarding an incident of alleged abuse, indicated that the home had not completed an investigation into the alleged abuse of a resident by a staff member.

The Director of Care (DOC) was interviewed and they stated that they had not conducted an internal investigation of the alleged abuse of a resident by a staff member.

Sources: Sources: CIS reports; home's policy "Abuse and Neglect, PM-12", last revised July 2020, review of the home's file notes; and interview with the DOC. [s. 23. (1) (a)] [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

Issued on this 29th day of October, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.