North District
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Original Public Report

Report Issue Date: November 24, 2022	
Inspection Number: 2022-1155-0001	
Inspection Type: Critical Incident System	
Licensee: Algonquin Nursing Home of Mattawa	
Long Term Care Home and City: Algonquin Nursing Home, Mattawa	
Lead Inspector Shannon Russell (692)	**Inspector Digital Signature**

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 14-18, 2022.

The following intake(s) were inspected:

- Four intakes, related to incidents of residents sustaining falls, resulting in a significant change in health status;
- Two intakes, related to incidents of resident-to-resident physical aggression, resulting in injuries; and,
- One intake, related to an incident of unknown origin that causes injury to a resident, resulting in transfer to hospital.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions between residents

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007, s. 6 (7).

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

Rationale and Summary
A Personal Support Worker (PSW) had heard raised voices and when they entered the area, a resident indicated that another resident had exhibited a specific responsive behaviour toward them. At the time of the incident, the resident who exhibited responsive behaviours was to have been provided with a specific intervention; however, the intervention had not been implemented when the incident occurred.

The resident's plan of care had indicated that they were to have the specified intervention in place at all times, due to their history of responsive behaviours.

PSW's, Registered staff, the home' Responsive Behaviour Lead, and the Director of Care (DOC), all identified that the resident was to have the specified intervention in place at the time of the incident, to prevent further incidents.

There was a moderate impact to the resident and a moderate risk to co-residents for not implementing the specified intervention for the resident.

Sources: CIS report; residents' health care records; the home's internal investigation notes; the home's policy titled, "BSO/Responsive Behaviours", #NM-E-26, last revised December 2019; and interviews with direct care staff, Registered Practical Nurse (RPN) Lead #115, and the DOC. [692]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques, specific to using a type of assistance when they provided care to a resident.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Rationale and Summary
A RPN observed that a resident had an injury to an identified area; the PSW providing care to the resident indicated that they had not known how the resident sustained the injury. The PSW indicated to the RPN that they had provided a type of assistance to the resident for their activity of daily living (ADL).

The resident's plan of care at the time of the incident, indicated that they required a different type of assistance with the completion of this specific ADL.

Direct care staff and the DOC identified that staff were to always follow the specific type of assistance as per the resident's plan of care when completing the specific ADL, for the safety of the residents.

There was a moderate risk of injury for the resident when the PSW did not provide the resident with the type of assistance required when completing the specific ADL.

Sources: CIS report; review of a resident health care records; "Minimal Lift Policy and Procedures", #NM-M-09, last revised October 2022; internal investigation notes; Interviews with direct care staff, and the DOC. [692]