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: April 11th 2024
Inspection Number: 2024-1155-0001
Inspection Type: Complaint Critical Incident
Licensee: Algonquin Nursing Home of Mattawa
Long Term Care Home and City: Algonquin Nursing Home, Mattawa

Lead Inspector	**Inspector Digital Signature**
Justin McAuliffe (000698)	Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2024.04.17 13:37:09 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2nd to 3rd 2024
The following intake(s) were inspected:

- One intake related to a Covid-19 Outbreak.
- One intake related to the improper care of a resident.
- One complaint: related to the improper care of a resident.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC #001 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 failed to ensure that a resident's individualized continence plan of care was implemented.

Rationale and Summary

A resident was assisted onto the commode by two Personal Support Workers (PSW). The PSW's left the resident alone on the commode to attend to another resident whose call bell was sounding. When the PSW's returned to assist the resident from the commode, they were found on the floor. The incident resulted in an injury to the resident.

The resident required constant supervision while on the commode, as indicated in the resident's care plan.

Interviews with staff noted that the resident requires constant supervision while on the commode for safety as per their plan of care, and that the staff member should

not have left the resident alone on the commode during the incident. The staff also confirmed that the expectation for staff is to stay with the resident while on the commode and allow other staff members to attend to the other resident's call bell.

The Director of Care (DOC) indicated in an interview that staff were expected to follow the plan of care and provide constant supervision to the resident while on the commode.

The resident was at an increased risk of falls and injuries when their individualized plan of care was not implemented.

Sources: Clinical records; Investigation Notes; Interviews with staff. [000698]