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

Public Report

Report Issue Date: July 23, 2025
Inspection Number: 2025-1155-0003
Inspection Type: Critical Incident
Licensee: Algonquin Nursing Home of Mattawa
Long Term Care Home and City: Algonquin Nursing Home, Mattawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 21 to 22, 2025

The following intake(s) were inspected:

- One intake related to neglect.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect neglect of a resident, that the suspicion was immediately reported to the Director.

Sources: A resident's clinical records; A critical incident; Interview with staff.

WRITTEN NOTIFICATION: Transfers and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when transferring a resident. Specifically, a resident did not receive a required intervention during a transfer.

Sources: A resident's clinical care records; Interviews with a resident and staff.

WRITTEN NOTIFICATION: Continence and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that a resident who was unable to toilet independently received the required assistance from staff during a specified period of time.

Sources: Interviews with a resident and staff; A resident's clinical care records; Records from the Long-Term Care Home.

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