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: April 11, 2025
Inspection Number: 2025-1469-0002
Inspection Type: Complaint Critical Incident
Licensee: Algoma Manor Nursing Home
Long Term Care Home and City: Algoma Manor Nursing Home, Thessalon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8- 10, 2025

The following intake(s) were inspected:

- One complaint Intake related to resident care;
- Two Intakes related to resident to resident physical abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when two resident's care needs changed.

While observing the two resident rooms it was noted that specific interventions were in place; however, their care plans did not reflect that the interventions.

Administrator stated that the interventions were to be noted in the resident's care plans.

Sources: Resident rooms observations, Care plans, Home's policy "Responsive Behaviours Management, and staff and Administrator interviews.

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