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: October 8, 2024
Inspection Number: 2024-1469-0002
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): September 23 to 27, 2024.

The following intake(s) were inspected:

- One Critical Incident intake related to an alleged improper/incompetent care of a resident by a staff member. Late reporting.
- One complaint intake related to alleged care neglect of residents.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Infection Prevention and Control
Palliative Care
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 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 use safe transferring and positioning devices or techniques when assisting residents.

A CI was submitted to the Director related to a resident who was improperly transferred by a staff member which resulted in an injury. This incident was verified by the Director of Care (DOC).

Sources: A CI Report; review of the resident's medical records, and interview with the DOC.

WRITTEN NOTIFICATION: Skin & Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident who exhibited an altered skin integrity received the required treatment and interventions to promote healing and prevent infection.

A registered staff had provided a wound care treatment to a resident but did not follow the wound care order. The Charge Nurse and the DOC acknowledged that the registered staff was supposed to follow the resident's wound care order, but this did not occur.

Sources: A complaint intake; review of the resident's medical records and the home's policy, interview with Charge Nurse #112, and the DOC.

WRITTEN NOTIFICATION: Critical Incident - Late Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the

resident's health condition.

The licensee has failed to ensure that the Director was informed no later than one business day when a resident sustained an injury related to an improper transfer that impacted the resident's health condition.

The DOC acknowledged that the critical incident report involving the specified resident was reported one-business day late.

Sources: A CI report; review of resident's medical records and the home's policy, and interview with the DOC.

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