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
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Original Public Report

Report Issue Date: January 18, 2024
Inspection Number: 2023-1552-0002
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the City of Timmins
Long Term Care Home and City: Golden Manor, Timmins

Lead Inspector	**Inspector Digital Signature**
Chad Camps (609)	Chad A Camps Digitally signed by Chad A Camps Date: 2024.01.30 12:52:53 -05'00'

Additional Inspector(s)
Samantha Fabiilli (000701)

INSPECTION SUMMARY

The inspection occurred onsite between November 20-24, 2023. Offsite inspection activities occurred on November 27 and 30, 2023.

The following intake(s) were inspected:

- One intake related to a missing resident;
- One intake related to a resident who fell;
- One intake related to an elopement of a resident; and
- Two intakes related to allegations of abuse of a resident.

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

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

Non-Compliance (NC) #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the policies and procedures relating to dietary services were implemented.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that there were policies and procedures in place relating to dietary services, and that these policies and procedures were complied with.

Specifically, the home did not comply with their "Food Safety" policy within the

Dietary Services department.

Rationale and Summary

The home's policy titled "Food Safety" indicated that internal food temperatures were to be checked during and after cooking, and prior to meal service, and that these temperatures were to be recorded. The home's temperature logs, only identified one section for documenting the alternative options for the menu, not designating sections for the different textures.

Not specifying the modified textures for recording food temperatures in the temperature logs posed a moderate risk to the residents.

Sources: Review of previous and updated cooks daily log temperatures; The home's policy titled "Food Safety"; Interviews with dietary staff and management. [000701]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff involved in the different aspects of care of a resident, collaborated with each other in the implementation of the plan of

care, so that the different aspects of care were consistent with and complimented each other.

Rationale and Summary

A resident's current care plan did not indicate that they required an assistive device. The Inspector observed staff utilize the assistive device with the resident. Personal Support Worker (PSW) staff indicated that the assistive device was used when providing care to the resident because physiotherapy identified the need for its use.

However, staff had communicated that there were concerns with the resident when the assistive device was used. The resident's medical staff were aware of physiotherapy's recommendation and the staff's concerns with the assistive device and indicated that the resident did not require the assistive device.

Despite the medical staff's recommendation and the resident's current care plan, PSW staff were still utilizing the assistive device.

Not utilizing collaboration in the implementation of the resident's care so that the aspects of care were consistent and compliment each other, posed moderate risk to the resident.

Sources: Observations of a resident; Interviews with PSW staff and management; A resident's progress notes and current care plan. [000701]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1. The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary

A resident's Point of Care (POC) records contained no documentation that any care was provided to the resident during a shift.

Personal support staff assigned to the resident on that shift stated that the care was provided but that they had forgotten to record the care in POC.

The home's failure to document the provision care set out in a resident's plan of care presented low risk to the resident.

Sources: A resident's POC documentation; Interviews with PSW staff and management. [609]

2. The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary

Staff were ordered to check on a resident at specific intervals. A gap was identified where no staff had recorded the checks on the resident.

Registered staff verified the gap in the resident's documentation.

The gap in documentation presented low risk to the resident.

Sources: A resident's health care records; Interviews with registered staff and management. [609]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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.

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary

A resident was observed with an assistive device.

A progress note indicated that the resident was provided the assistive device which was not identified in the resident's current care plan.

PSW staff and registered staff indicated that the resident used the assistive device.

Not revising the resident's plan of care when their care needs changed resulted in a low risk to the resident.

Sources: Observations of a resident; A resident's progress notes and current plan of care; Interviews with PSW, registered and management staff. [000701]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that all assessments were documented in relation to the use of a device on a resident.

Rationale and Summary

A resident was observed with a device applied.

The home's policy indicated that the Registered Nurse (RN) was responsible to complete the initial assessment prior to the use of the device.

Not documenting assessments of the resident prior to applying the device posed a low risk to the resident.

Sources: Observations of a resident; Interview with management; Review of a resident's progress notes; and the home's policy. [000701]