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 20, 2026
Inspection Number: 2026-1552-0001
Inspection Type:
Complaint
Critical Incident

Licensee: The Corporation of the City of Timmins
Long Term Care Home and City: Golden Manor, Timmins

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 13 to 17, 2026.

The following intake(s) were inspected:
- One intake related to an abuse of a resident by a visitor;
- One intake related to an alleged abuse of resident by staff members, and
- One complaint intake related to concerns of improper care of residents and the operation of the LTCH.

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

Skin and Wound Prevention and Management
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Police notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

A staff member had witnessed an incident of resident abuse and the appropriate police force was not immediately notified.

Sources:
CI report; resident clinical record review; review of the home's policy, "Zero Tolerance Abuse and Neglect", observation of the home, and interview with the resident and a staff member.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 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.

On a specified date, a resident fell and sustained an injury that required transfer to hospital. This incident was not reported to the Director within one business day.

Sources: Resident observation; resident clinical record review and the home's policy, "Falls and Injury Prevention Program", interview with the resident and a staff member.

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