Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 2022	2022_899609_0001	015132-21	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. Timmins ON P4N 5H3

Long-Term Care Home/Foyer de soins de longue durée

Golden Manor
481 Melrose Boulevard Timmins ON P4N 5H3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10-14 and January 17-21, 2022.

One complaint intake was inspected on during this Complaint inspection.

A Critical Incident System (CIS) inspection #2022_899609_0002 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents and family of residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Facilities Supervisor, Nurse Practitioner (NP), Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers and Screeners.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of resident care and services, observed staff and resident interactions, observed infection control practices, reviewed relevant health care records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) fully participated in the decision to implement revisions to the resident's plan of care.

Registered Nurse (RN) staff assessed a resident and decided they no longer required an identified fall intervention. They then revised the resident's plan of care and removed their identified fall intervention without any involvement by their SDM in the decision.

The RN who performed the assessment verified that despite the resident's inability to make their own treatment decisions, the RN decided without the participation of resident's SDM, to remove the identified fall intervention. The RN acknowledged that the resident's SDM should have been involved in the decision.

The home's policy, ADOC and DOC all verified that the resident's SDM should have fully participated in the decision to remove the resident's identified fall intervention.

The home's failure to ensure that resident #001's SDM fully participated in the decision to implement revisions to their plan of care presented actual risk to the resident who was at risk of falling.

Sources: a resident's electronic health care records, the home's policy titled "Resident Care Planning" policy #COT-GM-NRC-C-01-v.01, interviews with a resident, RN staff, ADOC and DOC. [s. 6. (5)]

2. The licensee has failed to ensure that care was provided to a resident as specified in their plan of care.

A resident's plan of care required an identified intervention for safe transporting because the resident was at a risk for falls.

During the inspection, the Inspector observed a resident be transported by Personal Support Worker (PSW) staff without the identified intervention. PSW staff verified that they should have implemented the identified intervention before they transferred them, but had forgotten. The home's policy, ADOC and DOC all verified that PSW staff should have implemented the identified intervention before they transported the resident.

The home's failure to implement the identified intervention before transporting the resident resulted in actual risk to the resident who had a history of falling when the identified intervention wasn't implemented.

Sources: observations of a resident, a resident's electronic health care records, the home 's policy titled "Resident Handling Program" policy #COT-GM-NRC-L-05 v.05, interviews with PSW staff, ADOC and DOC. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001's SDM fully participates in the decision to implement revisions to the resident's plan of care as well as ensure that care is provided to resident #001 as specified in their plan of care, to be implemented voluntarily.

Issued on this 4th day of February, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.