Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: May 23, 2023	
Inspection Number: 2023-1552-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: The Corporation of the City of Timmins	
Long Term Care Home and City: Golden Manor, Timmins	
Lead Inspector Shelley Murphy (684)	**Inspector Digital Signature**
Additional Inspector(s) Justin McAuliffe (000698)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-4, 2023.

The following intake(s) were inspected:
- One Intake: related to a resident fall; and
- One Intake: related to resident safety

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

Safe and Secure Home
Infection Prevention and Control
Falls Prevention and Management

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 (1) (c)

Rationale and Summary

The licensee of a long-term care home failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

During a review of a resident's care plan it had two conflicting interventions.

The risk to the resident is low related to this non-compliance.

Sources
Complaint submitted to the Director, Resident #003's care plan, home's policy, staff and ADOC interviews.
[684]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Rationale and Summary
The licensee of a long-term care home failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

Upon review of the progress notes, there were notes indicating that this resident did not follow the parameters in one of the home’s policies.

The care plan for this resident was reviewed and it indicated that the resident was aware of the home’s policy and the specific requirements they were to follow as it related to the policy, but the resident’s plan of care had not been revised despite being ineffective.

The risk to the residents is moderate related to this non-compliance.

Sources

Complaint submitted to the Director, Resident #004s care plan and progress notes, home's policy, resident's, staff and ADOC interviews.
[684]