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: August 30, 2024.

Inspection Number: 2024-1552-0001

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): August 12-16, 2024.

The following intake(s) were inspected:

- Intake: related to a fall with injury.
- Intake: related to an outbreak.
- Intake: related to a complaint and concerns of potential improper/incompetent care of residents.
- Three Intakes: related to potential sexual abuse of a resident.
- Intake: related to potential sexual abuse of residents.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their fall prevention and management program when a resident had an unwitnessed fall with injury.

In accordance with O. Reg. 246/22 s. 11. (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program, including relevant procedures, provides for methods to reduce risk and monitor outcomes, where required, and is complied with.

Specifically, the home did not comply with the licensee's policy, Falls and injury prevention program. The registered staff were to collaborate with the team to

determine the cause of the fall and conduct a Post-Fall Investigation Assessment/Huddle. Post hospitalization/transfer to hospital the Registered Nurse (RN) was to review the residents care plan to ensure that any applicable changes had been made.

Rationale and Summary

On a specific day, a resident had an unwitnessed fall that resulted in an injury and change to their functional status.

a) This resident had a specific fall intervention in place to prevent an injury, and at the time of the fall it was documented that a personal Support Worker (PSW) stated, the resident was not using the fall intervention.

b) Upon return from the hospital the resident required a mobility device. The resident's care plan was not immediately updated.

c) The home's policy required a Post-Fall Investigation Assessment/Huddle assessment in Point Click Care (PCC) was to be completed after a resident fell. This resident did not have this assessment completed after their fall.

The Assistant Director of Care (ADOC) stated that this resident required to have their fall intervention in place; and when the resident's care needs changed their care plan should have been updated immediately; and that the process of using the Post-Fall Investigation Assessment/Huddle assessment should have been completed at that time.

Sources: Interviews with ADOC, PSW, and other staff; review of the resident clinical records, the Critical Incident (CI); and falls and injury prevention program, policy.

WRITTEN NOTIFICATION: Police Notification

NC #002 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).

The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witness incident of abuse involving specific residents.

Rationale and Summary

Critical incidents (CIs) were submitted to the Director, in relation to potential sexual abuse, between specific residents.

On review of the progress notes, and risk management reports, the police were not informed of the specific incidents. Interview with an RN identified they had investigated the specific incidents and had informed their supervisors and the police had not been contacted.

After review of the home's Abuse policy, the police are to be notified, if alleged,

suspected, witnessed or un-witnessed incident of abuse or neglect of a resident may constitute a criminal offence.

After, review with the Administrator, the police should have been informed in order to identify if the incident was a criminal offence or not. There had been minimal impact to the resident's health, safety, and quality of life at the time of the incident.

Sources: Critical Incidents (CIs); investigation notes; head to toe assessments; risk management reports; progress notes; Zero Tolerance Abuse and Neglect policy; interview with, Administrator, and nursing staff.