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

**Central West District**
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# Public Report

**Report Issue Date:** August 29, 2025

**Inspection Number:** 2025-1582-0003

**Inspection Type:**
Critical Incident

**Licensee:** Corporation of the County of Simcoe

**Long Term Care Home and City:** Simcoe Manor Home for the Aged, Beeton

## INSPECTION SUMMARY

Inspection Summary

The inspection occurred onsite on the following date(s): August 22, and 25 - 29, 2025.

The following intake(s) were inspected:
- Intake: #00149729: related to an allegation of improper care of a resident.
- Intake: #00151736, and Intake: #00153324: related to the home's fall prevention program.
- Intake: #00155010: related to outbreak management

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirements 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised 2023), the licensee has failed to ensure that when a resident had symptoms of infection they were placed on the appropriate additional precautions of droplet contact isolation, specifically section (b) evidence-based practices related to potential droplet transmission and required precautions.

A resident showing symptoms of a respiratory infection was not isolated with the correct additional precautions until eight days after the onset of their symptoms.

**Sources:** Review of a resident's progress notes, interview with a Registered Practical Nurse (RPN) and Infection Prevention and Control (IPAC) lead.

## WRITTEN NOTIFICATION: Infection prevention and control

## program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that when a resident had symptoms of a respiratory infection that immediate action was taken to reduce transmission of infection and isolate the resident.

The home did not take immediate action to assess or isolate a resident to stop the spread of infection when it was first reported that they were showing signs of a respiratory infection.

Further testing for the resident confirmed positive test results for a respiratory infection. A respiratory outbreak was later declared eleven days after the initial resident became symptomatic and involved additional residents.

**Sources**: A resident's progress notes, interview with an RPN and the home's IPAC lead.