Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2019	2019_773155_0014	014750-19, 016508-19	Follow up

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 24, 25, 26 and October 1, 2019.

Tawnie Urbanski, Inspector #754 was also present during inspection.

The following intakes were completed within this Follow up inspection:
Log 014750-19 follow up to Compliance Order #001 from inspection number 2019_773155_0010 related to neglect and
Log 016508-19 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with Administrator, Administrative Assistant, Director of Resident Care, Resident Care Supervisor, Physician, Quality Improvement Coordinator, former Assistant Director of Resident Care, Registered Nurse, Registered Practical Nurse and Personal Support Workers.

The inspectors also toured an identified resident living area; reviewed relevant clinical records, policies and procedures, schedules, the home's investigation notes; and observed resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_773155_0010	155

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when they informed the Director of an incident of an unexpected death of a resident, that the report in writing to the Director set out actions taken in response to the incident, including, what care was given or action taken as a result of the incident, and by whom, and the outcome or current status of the individual or individuals who were involved in the incident.

On an identified date, the home submitted a Critical Incident Report for an unexpected death of an identified resident. The Critical Incident Report was not amended to include the resident's diagnoses, the information identified on the Institutional Patient Death Record and the cause of death. The critical incident indicated that the events of an identified date had been reviewed with a RPN and RN however it did not include the outcome of the review.

The Administrator shared that they were not aware that the Critical Incident was not amended to include the cause of death and the outcome of the home’s investigation done to date.

The licensee failed to ensure that when they informed the Director of an incident of an unexpected death, that the report in writing to the Director set out actions taken in response to the incident, including, what care was given or action taken as a result of the incident, and by whom, and the outcome or current status of the individual or individuals who were involved in the incident. [s. 107. (4) 3.]

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 a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
Actions taken in response to the incident, including,
i) what care was given or action taken as a result of the incident, and by whom, and
v) the outcome or current status of the individual or individuals who were involved in the incident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident's written record was kept up to date at all times.

On an identified date, the home submitted a Critical Incident Report for an unexpected death of a resident.

The identified resident's progress notes, documented on the day of the resident's death, did not include if the registered nurse (RN) or physician had been notified by the registered practical nurse (RPN) that the identified resident had a change in status and required interventions.

Three days after the incident the RPN made a late entry in the identified resident's progress notes. Thirty-five days after the incident the RN made a late entry in the identified resident's progress notes.

During an interview with the Administrator and Director of Resident Care they shared that the expectation was that documentation was to happen at the time of the event or as soon as possible after the staff member had handled the event.

The licensee failed to ensure that the resident's written record was kept up to date at all times. [s. 231. (b)]

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 the resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 7th day of October, 2019

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

Original report signed by the inspector.