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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2022	2022_773155_0002 (A2)	000443-22, 001635-22	Complaint

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

Amended by JANET GROUX (606) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

There is one order in this report. The CDD will be extended to May 20, 2022.

Issued on this 29th day of April, 2022 (A2)

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

Original report signed by the inspector.

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

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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
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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

Amended by JANET GROUX (606) - (A2)

Amended 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 24-28, January 31-February 4, February 7 to 11, 2022.

The following intakes were completed during this complaint inspection:

Log #000443-22 related to responsive behaviours and alleged abuse; and

Log # 001635-22 related to concerns with accommodation charges, medications, bathing, and weight loss.

A written notification and compliance order related to O.Reg. 79/10 s. 135.(2) was identified in this inspection and has been issued in a concurrent inspection, #2022_773155_0001, dated March 7, 2022.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DOC), Administrative Assistant, Medical Director, Acting Resident Care Program Supervisor (ARCPS), Director of Operations-Universal Care Canada Incorporated (UCCI), Director of Clinical UCCI, External Behaviour Support Ontario staff, Security staff, Medisystem Pharmacist Consultant, Medisystem Operations Manager, RAIMDS Coordinator, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents.

During the course of the inspection, the inspectors observed resident and staff interactions, infection prevention and control practices, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Resident Charges
Responsive Behaviours

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

2 WN(s)
1 VPC(s)
1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to behaviours, and that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented (O. Reg. 79/10 s. 53 (4) (b) and (c)).

a) An incident occurred with resident #016. The home stated they immediately implemented a specific level of monitoring in relation to the resident's responsive behaviours. The home also indicated they followed their Responsive Behaviour Program Policy (D-20), which included implementation of other interventions, and that interventions were to be care planned.

During the inspection it was observed that interventions were not implemented as indicated. The resident's responses to interventions were not always documented. Interventions were not in the care plan.

Sources: Observations on January 25, 26, and February 3 of 2022, Policy Responsive Behaviour Program D-20, DOC interview, UCCI staff interview, and other staff.

b) Resident #017 was identified to have a specific intervention to help manage responsive behaviours.

During the inspection it was observed that the specific intervention was not in place. The DOC was interviewed and acknowledged that the intervention was not

in place at all times.

A staff member who worked on resident 017's home area was not aware of when specific interventions were to be in place. The staff member was unable to find directions in the physical chart and nursing communication tool and requested assistance from another staff member. That staff member was not able to find directions for the intervention in the physical or electronic chart and was observed to call the RN and administration team with no success in obtaining information.

The assessment tool for a month, showed 9 days where assessments were not documented during specific shifts. Weekly high risk round meetings were not conducted on 4 specific weeks. A referral for an on-staff responsive behaviour resource nurse was left without response, 56 days overdue. A specific intervention were not documented in the care plan.

Sources: Observations on February 1, 2, and 3 of 2022, Policy Responsive Behaviour Program D-20, DOC interview, and staff interviews.

c) Resident #027 was identified to require a specific intervention to manage responsive behaviours.

The assessment tool for a month, showed 6 days in which assessments were not documented during specific shifts. Weekly high risk round meetings were not conducted for over 11 weeks. Three referrals for the on-staff responsive behaviours resource nurse were left without response, 34 days overdue, 39 days overdue, and 67 days overdue. A specific intervention was not documented in the care plan.

The DOC was interviewed and acknowledged that interventions were to be in the care plan, and that high risk rounds were to be held weekly.

The home stated they did not have an on-staff responsive behaviour resource nurse. All referrals in the home were automatically forwarded to the external behavioural support team (BSS). An audit was conducted that showed there were 16 referrals overdue in the home. Nine of these referrals were not shared with the BSS team which included physically responsive behaviors.

Failure of the home to implement identified interventions consistently for resident #016. #017 and #027 and ensure complete and accurate documentation of

interventions, assessments and reassessments may have impeded the home's ability to minimize further incidents, identify causes and triggers, behavioural trends, and evaluate interventions putting other residents at further risk of harm.

Sources: Review of resident #027 electronic documentation, Policy Responsive Behaviour Program D-20, DOC interview, and other staff interviews. [s. 53. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was bathed according to their choice.

The resident's plan of care documented that the resident was to be bathed as per their preference.

During a nine week period, the resident missed six baths. On two occasions,the resident was not provided with a tub bath and on four occasions when the resident refused their bath, there were no actions taken to re-approach the resident or provide alternatives.

The home's RAIMDS Coordinator and a PSW said that the resident should be re-approached when they refused their bath and alternatives provided, such as a full body sponge bath. In addition, staff were expected to document the attempts and the results of these actions.

By not ensuring that the resident was bathed according to their preference, increased the risks associated with not meeting the resident's hygiene requirements.

Sources: resident's progress notes, Point of Care (POC) documentation, and interviews with the home's RAIMDS Coordinator and PSW. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 29th day of April, 2022 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JANET GROUX (606) - (A2)
Inspection No. / No de l'inspection :	2022_773155_0002 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000443-22, 001635-22 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 29, 2022(A2)
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, Collingwood, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Astrida Kalnins

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with s. 53. (4) of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure that resident #016, #017 and #027 are assessed and/or reassessed in relation to their responsive behaviours.

b) Ensure that interventions identified for resident #016, #017 and #027 in relation to their responsive behaviours, are implemented, documented in their care plan and the resident responses to the interventions are documented.

c) Ensure that the home has an individual assigned as the on-staff responsive behaviour resource nurse and that responsive behaviour referrals are completed by them or their designate, within seven days.

d) Develop and implement a process to ensure direct care staff are aware of when a resident requires 1:1 staff support, specific time-frames for the support; and staff responsibilities when the 1:1 can not be provided.

e) Develop and implement a weekly audit for resident's with responsive behaviours to ensure the DOS is completed and that residents are reviewed at high risk rounds. The audit is to be kept available in the home.

Grounds / Motifs :

1. a) An incident occurred with resident #016. The home stated they immediately implemented a specific level of monitoring in relation to the resident's responsive behaviours. The home also indicated they followed their Responsive Behaviour Program Policy (D-20), which included implementation of other interventions, and that interventions were to be care planned.

During the inspection it was observed that interventions were not implemented as indicated. The resident's responses to interventions were not always documented. Interventions were not in the care plan.

Sources: Observations on January 25, 26, and February 3 of 2022, Policy Responsive Behaviour Program D-20, DOC interview, UCCI staff interview, and

other staff.

b) Resident #017 was identified to have a specific intervention to help manage responsive behaviours.

During the inspection it was observed that the specific intervention was not in place. The DOC was interviewed and acknowledged that the intervention was not in place at all times.

A staff member who worked on resident 017's home area was not aware of when specific interventions were to be in place. The staff member was unable to find directions in the physical chart and nursing communication tool and requested assistance from another staff member. That staff member was not able to find directions for the intervention in the physical or electronic chart and was observed to call the RN and administration team with no success in obtaining information.

The assessment tool for a month, showed 9 days where assessments were not documented during specific shifts. Weekly high risk round meetings were not conducted on 4 specific weeks. A referral for an on-staff responsive behaviour resource nurse was left without response, 56 days overdue. A specific intervention were not documented in the care plan.

Sources: Observations on February 1, 2, and 3 of 2022, Policy Responsive Behaviour Program D-20, DOC interview, and staff interviews.

c) Resident #027 was identified to require a specific intervention to manage responsive behaviours.

The assessment tool for a month, showed 6 days in which assessments were not documented during specific shifts. Weekly high risk round meetings were not conducted for over 11 weeks. Three referrals for the on-staff responsive behaviours resource nurse were left without response, 34 days overdue, 39 days overdue, and 67 days overdue. A specific intervention was not documented in the care plan.

The DOC was interviewed and acknowledged that interventions were to be in the care plan, and that high risk rounds were to be held weekly.

The home stated they did not have an on-staff responsive behaviour resource nurse. All referrals in the home were automatically forwarded to the external behavioural support team (BSS). An audit was conducted that showed there were 16 referrals overdue in the home. Nine of these referrals were not shared with the BSS team which included physically responsive behaviors.

Failure of the home to implement identified interventions consistently for resident #016. #017 and #027 and ensure complete and accurate documentation of interventions, assessments and reassessments may have impeded the home's ability to minimize further incidents, identify causes and triggers, behavioural trends, and evaluate interventions putting other residents at further risk of harm.

Sources: Review of resident #027 electronic documentation, Policy Responsive Behaviour Program D-20, DOC interview, and other staff interviews.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to resident #016, #017 and #027 when strategies were not implemented to respond to their behaviours and the resident's responses to interventions were not documented.

Scope: Three out of three residents reviewed, did not have interventions in place and responses to interventions documented, demonstrating widespread non-compliance.

Compliance History: Nine written notifications (WNs), 44 voluntary plans of correction (VPCs) and 31 compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months.
(705751)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2022(A2)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of April, 2022 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JANET GROUX (606) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Central West Service Area Office