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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: June 20, 2025

Inspection Number: 2025-1587-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Sunset Manor Home for Senior Citizens, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-6, 9-13, and 17-19, 2025
The inspection occurred offsite on the following date(s): June 17, 2025
The following intake(s) were inspected:

- Intake: #00141876 related to falls prevention and management
- Intake: #00142271 related to Improper care of a resident
- Intake: #00144502 related to Influenza A Outbreak
- Intake: #00146769 related to medication management
- Intake: #00146900 complaint related to physiotherapist and occupational therapist services
- Intake: #00146955 complaint related to improper care of a resident
- Intake: #00145885 complaint related to skin and wound care
- Intake: #00146418 complaint related to falls prevention and management

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the resident's plan of care was revised when the resident required a different intervention related to skin and wound care.

On June 5, 2025, the resident's plan of care was revised to include the updated interventions.

Sources: Long-Term Care Homes (LTCH) Inspector's observations, resident's progress notes and care plan, and interviews with the resident, Personal Support Worker (PSW) and Registered Practical Nurse (RPN).

Date Remedy Implemented: June 5, 2025

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the fall risk assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The falls risk assessment of the resident were inconsistent in fall risk level assessment completed by registered staff members.

Falls Lead stated registered staff should have completed fall risk assessment appropriately to ensure assessments are consistent.

Sources: Clinical Record Review of the resident and Interview with Falls Lead.

WRITTEN NOTIFICATION: Involvement of resident, etc

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute

decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's Substitute Decision-Maker (SDM) was given an opportunity to fully participate in the development and implementation of the resident's plan of care related to wound care.

Sources: resident's progress notes, skin and wound evaluations, the home's complaint record, and interviews with RPN and the Wound Care Lead.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (5)
24-hour admission care plan
s. 27 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 246/22, s. 27 (5).

The licensee failed to ensure that the substitute decision-maker are given an opportunity at admission to participate to the extent possible in the development and implementation of the resident's care plan.

The resident's substitute decision-maker (SDM) was not notified immediately after an incident with the resident as discussed with the SDM at admission and the care plan was not updated with this intervention at admission.

Sources: Clinical Record Review of the resident and Interview with Falls Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 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 staff followed any standard or protocol issued by the Director with respect to infection prevention and control.

In accordance with the IPAC Standard, revised September 2023, section 9.1 (f) the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: additional PPE requirements including appropriate selection application, removal and disposal.

As a staff member did not don appropriate PPE before entering a resident's room as required according to additional precaution signage posted.

Sources: Observations, resident clinical records, and interview with staff.

WRITTEN NOTIFICATION: Infection Surveillance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that the resident's symptoms were monitored on every shift, three times a day during the presence of infection.

In accordance with O. Reg. 246/22 s. 11 (1) b, the licensee is required to ensure all residents experiencing symptoms of any type of infection are monitored three times a day. Specifically, the home's Infection Surveillance in Long Term Care Setting policy directs staff to document infection progress note in the resident's electronic health record three times a day until the symptoms have resolved.

The staff failed to document monitoring of the resident's symptoms three times each day during time of infection.

Sources: Infection Surveillance in Long term Care policy, resident clinical records and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug was administered to the resident unless the drug was prescribed for the resident.

A medication error was made when an Registered Practical Nurse (RPN) administered a drug to a resident which was not prescribed for them.

Sources: Critical incident report, Policy: Medication Administration, medication incident report, progress notes, interview with the resident, RPN and DOC.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Ensure that all registered nursing staff who completed the wounds assessments and treatments for the identified resident receive re-training on the skin and wound program including recognizing signs and symptoms of wound infection and deterioration, and appropriate actions they are expected to take, and completing weekly skin and wound assessments. A copy of the training record including the date of the training, the content, the name of the staff trained, and the name of the person who provided the training should be kept at the home.

Grounds
The licensee has failed to ensure that a resident received immediate interventions to promote healing and prevent infection of their wounds.

A resident had multiple areas of skin concerns. One of the resident's areas of skin concerns had signs of infection and immediate interventions to prevent infection

and further deterioration were not implemented.

When staff did not identify signs and symptoms of wound infection and deterioration, immediate interventions to promote healing and prevent infection were not implemented, which resulted in long standing infection and delayed healing of resident's skin and the deterioration of the wounds.

Sources: resident's progress notes, skin and wound evaluation assessments, physician's orders, electronic Treatment Administration Records (eTARs), the home's Wound Management Program policy, a complaint record, and interviews with RPN, the home's Wound Care Lead, Director of Resident Care (DRC) and Physician.

This order must be complied with by July 31, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same

requirement.

Compliance History:

In the past 36 months, a CO under [O. Reg. 246/22], s. 55 (2) (b) (ii) was issued under inspection #2022-1587-0003) on October 3, 2022, and resulted in a $5,500, AMP.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure:

1) Conduct weekly audits of the identified resident 's skin and wound assessments for minimum four weeks. These audits should include the date and time of the audit, the name of the person who completed the audit, the name of the staff who completed the assessment, the wound assessment being audited and compared with the Wound app picture for accuracy, whether there were signs of infection or deterioration, if a follow up action was taken as required, and details of any gaps or inaccuracies in the assessment. A copy of these audits should be kept at the home.

Grounds
The licensee has failed to ensure that the resident received accurate weekly reassessments of their wounds.

The resident had multiple skin tears. On multiple occasions the weekly wound assessments completed for these skin concerns included inaccurate documentation which resulted in failure to identify the signs and symptoms of wound infection in a timely manner and delayed healing of the skin tears.

When staff failed to ensure accurate assessments of the resident's wounds, it made it difficult to determine the actual progress of these wounds and delayed the implementation of the appropriate actions, which resulted in prolonged infection and delayed healing of their skin tears and deterioration of their pressure injuries.

Sources: the resident's progress notes, weekly skin and wound evaluations, the home's Wound Management Program, and interviews with RPN, the home's Wound Care Lead, DRC and Physician.

This order must be complied with by July 31, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance

order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO under [O. Reg. 246/22], s. 55 (2) (b) (iv) was issued under inspection #2022-1587-0002, on September 13, 2022, and resulted in a $5,500, AMP.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services

(PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Falls prevention and management

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Review the residents falls on the identified period of time and complete an audit on each fall. The audits shall include information as it relates to the date of the fall, the type and location of fall, any interventions that were required at the time of the fall as per the resident's plan of care, the interventions that were in place at the time of fall, potential staff involved, and any injuries sustained as a result of the fall. If any required interventions were not in place at the time of a fall, include any follow up or education that was completed including who received it and when it was completed.
2. Maintain a record of the completed audits from Part 1, including the name of residents, dates and times of the falls, and whether the required interventions were in place at the time of the fall. Ensure the records are available upon Inspector request.
3. If staff knowledge gaps are identified as a result of the audits, provide re-

education or training to applicable staff on the home's Falls Management program, or any other relevant policies or procedures if applicable.
4. Maintain a record of re-education or training that was completed in Part 3. Ensure the records include the contents reviewed, date and time of review, name of staff that provided re-education, and name of staff receiving re-education including their signatures of completion. Ensure these records are available upon Inspector request.

Grounds
The licensee failed to ensure that the strategies to reduce or mitigate falls for the identified residents were implemented.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that there are strategies to reduce or mitigate falls and that they are complied with.

A) A resident was transferred to their mobility device and the PSW failed to ensure that appropriate falls interventions were in place for the resident. As a result they were placed at increased risk of falling and subsequent harm or injury.

Sources: Critical incident report, Policy: Falls Management Program (NPC D-25), progress notes, home's investigation notes, interviews with PSW and DOC.

B) The resident had a fall and at the time of fall, it was identified that an intervention related to falls prevention and management was not in place.

Sources: Investigation notes, Policy: Falls Management Program (NPC D-25), interview with staff

This order must be complied with by July 31, 2025

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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