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: August 13, 2025

Inspection Number: 2025-1587-0004

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): July 23-25, 28-31, 2025 and August 1, 12, and 13, 2025.
The inspection occurred offsite on the following date(s): August 11, 2025.

The following intake(s) were inspected:
-Intake: #00147151 related to an fall resulting in injury
-Intake: #00149326 , #00149541, #00149787, #00149786 , #00151866 , #00151873, #00153779, #00153785, and #00153804 related to allegation of abuse and neglect, resident rights, retaliation and care concerns.

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

Resident Care and Support Services
Whistle-blowing Protection and Retaliation
Responsive Behaviours
Staffing, Training and Care Standards

Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee failed to ensure a resident's falls intervention was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the intervention had not been effective.

Staff stated the resident often refused the intervention and it was acknowledged that the care plan should have been revised to reflect refusal.

Sources: Inspector's observation, resident clinical records, and interviews with PSW, RPN and Fall's Lead.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 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 failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, and the use of equipment, supplies, devices and assistive aids for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes the use of devices and provides strategies to monitor residents, and must be complied with. The home's policy directs nursing staff to identify risks, implement fall prevention strategies, and evaluate the plan of care as needed. Additionally, they are to monitor to ensure Personal Support Workers (PSWs) are following the plan of care for fall prevention and management.

A resident was assessed to be at risk for falls. The resident's plan of care included falls interventions. On an identified date the resident had a fall and an intervention was not in place. During the inspection, the resident was observed by the inspector and falls interventions were not in place as per the plan of care.

Source: Inspector observations, falls management program policy, resident clinical records, interview with PSWs, RPN, and Fall's Lead.