

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: September 2, 2025

Inspection Number: 2025-1587-0005

Inspection Type:

Proactive Compliance Inspection

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): August 18 - 20, 22, 25 - 29, 2025 and September 2, 2025

The following intake(s) were inspected:

-Intake: #00155296 - Proactive Compliance Inspection

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Residents' and Family Councils
- Food, Nutrition and Hydration
- Medication Management
- Infection Prevention and Control
- Safe and Secure Home

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

Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that a resident was provided with the right to give or refuse consent to any treatment, care or services.

The resident was not able to exercise their right to give or refuse consent in an informed manner, when the method of delivery of pain management was not offered.

Source: Inspector's observation, prescriber's order, nursing plan of care, progress

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

note, medication administration record, interview with staff

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure residents' right to have their personal health information, within the meaning of the Personal Health Information Protection Act (PHIPA), 2004, kept confidential in accordance with that Act.

During medication pass, a staff did not dispose empty medication pouches in a specified container and failed to destroy them in a manner that maintained confidentiality.

Source: Inspector's observation, Medication administration policy (NPC E - 50 Review date May 6, 2025), interviews with staff

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that a two residents' treatment was documented accurately.

The treatment administration record and progress notes indicated that the treatment was done however, the staff did not document the treatment provided.

Sources: Clinical records, interview with staff

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee failed to ensure that the Pleasurable Dining Policy was followed at lunch meal service.

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

A staff failed to offer beverages at point of service, beverages were pre-poured and placed on tables before residents were seated, and the cold beverages on the beverage cart were not on ice.

Sources: Meal service observation, Pleasurable Dining Policy, Interview with staff

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The licensee failed to ensure there was a system to monitor and evaluate the food intake of residents.

A staff inaccurately documented food intake amount of the resident who was assessed to be a high nutritional risk.

Sources: Interviews with staff, resident's care plan and point of care (POC) intake, inspector observations

WRITTEN NOTIFICATION: Dining and snack service

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

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that food being served to residents was at a safe and palatable temperature.

During meal service, a staff checked the temperature of a dish that was to be served to a resident and documented as above acceptable temperature. After a corrective action was taken, the temperature was not re-taken to ensure they were at a safe and palatable temperature before being served to residents.

Sources: Temperature logs, Food Service Temperature policy, interview with a staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 has failed to ensure that the Standard issued by the Director related to

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

Infection Prevention and Control (IPAC) was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with related to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 9.1 (f) indicated additional PPE requirements including appropriate selection application, removal and disposal.

Two staff members did not wear a gown when they assisted a resident, who was on additional precaution.

Source: Care plan, Inspector observation, interview with staff

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

A prescribed topical medication was found stored in a non secure and unlocked container in the resident's room.

Source: Inspector observation, medication administration record, medication administration policy (NPC E - 50 Review date May 6, 2025), interview with staff

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

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.

Drug destruction and disposal

s. 148 (2) The drug destruction and disposal policy must also provide for the following:

2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that controlled substances that are to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

A staff did not waste two vials of used controlled substance immediately in the destruction pail, away from other active controlled substance.

Source: Inspector observation, physician's order, narcotics count sheet, Manual for medisystem serviced homes policies and procedures (August 2024), interview with staff