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: January 23, 2026

Inspection Number: 2026-1587-0001

Inspection Type:
Critical Incident
Follow up

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): January 6 - 8, 13 - 16, 19-23, 2026

The following intake(s) were inspected:
-Intake #00158098: Related to alleged neglect of a resident.
-Intake #00159778: Related to alleged sexual abuse of a resident.
-Intake #00160991: CO follow up #1 - O. Reg. 246/22 - s. 94 (1) - Pest control.
-Intake #00164354: Related to infection prevention and control.
-Intake: #00165267: Related to alleged improper care for resident and infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2025-1587-0007 related to O. Reg. 246/22, s. 94 (1)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

On a specified date, a resident who required assistance from staff was not checked on for a period of time. This resulted in the resident not receiving care for a period of time. When a staff member was alerted to the resident requiring assistance, they did not immediately assist the resident.

Sources: LTCH's investigation documents, resident's clinical documents, interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident had individualized strategies in place to respond to their responsive behaviours.

These strategies were not implemented on a specified date and as a result, staff did not respond to their behaviours as required.

Sources: Resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

Inspector completed multiple observations over two days in two separate dining rooms.

During the observations, the inspector observed mouse droppings in the same location for both dining rooms.

The mouse droppings were unchanged after the dining room floors had been cleaned.

Sources: Dining room observations, interviews with staff, housekeeping procedures.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #004 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 did not ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

A staff member was observed administering medications to multiple residents without performing hand hygiene between interactions.

Sources: Observations, IPAC Standard, and interviews with staff.