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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date July 19, 2022
Inspection Number 2022_1587_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the County of Simcoe

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

Lead Inspector
Sharon Perry #155

Additional Inspector(s)
Janis Shklinyk #706119
Nuzhat Uddin #532

Inspector Digital Signature
Sharon M Perry
Digitally signed by Sharon M Perry
Date: 2022.07.26 10:19:03 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-13 and May 17-19, 2022.

The following intake(s) were inspected:
- Intake # 008300-22 related to a fall resulting in injury
- Intake # 003888-22 related to alleged resident ot resident abuse
- Intake # 007947-22 and # 009619-22 Complaints related to medication administration
- Intake # 004937-22 Follow-up to Compliance Order (CO) #001 issued on March 7, 2022, under Inspection report # 2022_773155_0001 related to the Long-Term Care Home Act (LTCHA), s. 23.(1) (Immediate Investigate, Respond and Act to reported abuse and/or neglect) with a compliance due date of April 4, 2022.
- Intake # 004938-22 Follow-up to CO #002 issued on March 7, 2022, under Inspection Report # 2022_773155_0001 related to the LTCHA, s. 24.(1) (Immediate Report to Director) with a compliance due date of April 4, 2022.
- Intake # 004939-22 Follow-up to CO #003 issued on March 7, 2022, under Inspection Report # 2022_773155_0001 related to O. Reg 79/10 s.30.(2) (Actions under a program are documented) with a compliance due date of April 4, 2022.
- Intake # 004941-22 Follow-up to CO #005 issued on March 7, 2022, under Inspection Report # 2022_773155_0001 related to O. Reg 79/10 s. 131.(2) (Medication Administration) with a compliance due date of April 1, 2022.
- Intake # 004942-22 Follow-up to CO #006 issued on March 7, 2022, under Inspection Report # 2022_773155_0001 related to O. Reg 79/10 s. 229.(4) (Infection Control) with a compliance due date of April 4, 2022.

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s.30.(2)	2022_773155_0001	003	#155
O. Reg. 79/10	s.229.(4)	2022_773155_0001	006	#706119

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s.131.(2)	2022_773155_0001	005	#155

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be **CLOSED**.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
LTCHA, 2007	s.23.(1)	2022_773155_0001	001	#532
LTCHA, 2007	s.24.(1)	2022_773155_0001	002	#532

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (1) (c).
The licensee has failed to ensure that when a resident fell, there was clear directions to staff and others who provided direct care to the resident post fall.

Rationale and Summary
A resident had an unwitnessed fall that resulted in a significant injury and transfer to hospital.

Physiotherapist #110 completed an assessment of the resident, and recommended the resident be on a physiotherapy plan. Physiotherapist #110 said the resident should have the use of a wheelchair implemented as part of their care and not to use a walker.

Two staff were observed to help the resident up from the dining room chair, one on each side. The resident was provided a walker and not the recommended wheelchair.

One staff approached the resident outside of the dining room where they were seated in a chair with a walker nearby. The resident rocked themselves up from sitting to standing. The staff member had the resident use both sides of the walker. The resident became slightly unsteady and had to tilt themself over and bend down to reach the one side of the walker. The staff member walked alone with the resident into the dining room. The resident was observed bent over holding on to the walker with both hands.

A PSW stated that the resident required only one person for positioning and transferring, but that this could be different on different days.

An RPN stated the resident was a one person assist for positioning, transferring and ambulating, but since the resident was injured, they always used two people. The RPN was unsure of what direction had been given to staff related to care of a resident since their injury.

The resident's care plan said that the resident required the use of a walker for short distances and a wheelchair for long distances. However, the physiotherapist's recommendations directed staff not to use a walker due to their injury. For transferring, the resident's care plan documented extensive assistance from one staff and to be reminded to use a walker. The resident's transfer/mobility care plan/Kardex had not been updated, in order that clear direction was provided for staff caring for the resident. This put the resident at risk of further injury.

Sources: Sources: Interview with PSW, RPN, record review of the resident's, care plan, progress notes, observation of the resident, policy titled Falls Prevention and Management Program-Sunset Manor, effective date: August 2021. [706119]

WRITTEN NOTIFICATION DUTY TO PROTECT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.19. (1).

The licensee has failed to ensure that a resident was free from physical abuse by another resident.

For the purposes of the Act and this Regulation, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique") O. Reg. 79/10, s. 5.

Rationale and Summary

A Critical Incident (CI) report submitted to the Ministry of Long-Term Care, indicated that a staff member heard a resident calling out for help and yelling. The staff member observed that a co-resident had the resident held down in the chair, while the resident was attempting to break free. When the resident tried to break free; the co-resident slapped them. The resident expressed fear.

The resident that was slapped said that this incident bothered them.

Failure to provide the resident with assistance and protection placed the resident at potential risk of harm.

Sources: CIS report, review of residents' clinical records and progress notes, interviews with resident, Administrator and DORC.[532}

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24. (1) 2**.**
The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Rationale and Summary

An incident of physical abuse was observed by staff on an identified date.

A review of the Ministry of Long-Term Care (MLTC) Critical Incident (CI) reporting system showed that a CI related to resident-to-resident abuse was not submitted to the Director as per the Long-Term Care Home Act, 2007.

The Director of Resident Care acknowledged that the incident was documented in the progress note; however, it was not reported to the Director immediately.

Failure of the home to immediately report the abuse delayed the Director's ability to respond to the incident in a timely manner.

Sources: CIS reports, review of resident's clinical records and progress notes, interviews with resident, Administrator and DORC. [532]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii).

The licensee has failed to ensure that when a resident fell and sustained injuries resulting in bruising, the resident was assessed by a registered dietitian.

Rationale and Summary
The home's Wound Management Program, NPC D-35 SM, effective April 2022, stated that altered skin integrity is defined as potential or actual disruption of epidermal or dermal tissue. Deep tissue injury is a purple or maroon localized area of discoloured intact skin due to damage of underlying soft tissue from pressure and/or shear. Referrals will be completed to the Registered Dietician for any alteration in skin integrity.

A resident had an unwitnessed fall that resulted in a significant injury and transfer to hospital. On an identified date, it was documented in the initial skin assessment that the resident had bruising. Two days later, a progress note was documented stating that the resident had another area of bruising noted.

The Dietary Supervisor shared that a dietary referral was not received related to bruising for the resident.

The home not ensuring that the resident was assessed by a Registered Dietician related to the bruising may have resulted in the resident not receiving recommended nutritional interventions for healing.

Sources: Interview with Dietary Supervisor #113, record review of the resident's progress notes, assessments and care plan. [706119]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv).

The licensee has failed to ensure that when a resident fell and sustained bruising, that the resident was reassessed at least weekly by a member of the registered nursing staff for altered skin integrity.

Rationale and Summary
The home's Wound Management Program, NPC D-35 SM, effective April 2022, stated altered skin integrity is defined as potential or actual disruption of epidermal or dermal tissue. Deep tissue injury is a purple or maroon localized area of discoloured intact skin due to damage of underlying soft tissue from pressure and/or shear. All wounds, regardless of type, will be

assessed weekly, on return from hospital and after any leave greater than 24 hours by the registered staff and include wound measurements.

A resident had an unwitnessed fall that resulted in bruising. An initial skin assessment was conducted and there were no documented weekly skin assessments.

The Director of Resident Care said that the resident did not have weekly wound assessments completed related to their injury.

The home not ensuring that the resident was assessed weekly for bruising may have an impact on the treatment provided and healing.

Source: interview with DORC, record review resident's progress notes, assessments and care plan. [706119]

WRITTEN NOTIFICATION DINING AND SNACK SERVICE

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.79(1)8.

The licensee has failed to ensure that the resident was provided the personal assistance required to safely eat and drink as comfortably and independently as possible.

Rationale and Summary
A resident had an unwitnessed fall that resulted in an injury. The resident was required to wear a special device in relation to their injury.

The resident's meal assistance needs were documented in the care plan as requiring extensive assistance related to their injury.

The resident was observed sitting at the dining room table at lunch with food and fluids served to them. The resident sat with food in front of them for more than 30 minutes before beginning to eat their meal on their own while trying to use their injured arm. Staff were not observed to offer the resident assistance during their meal.

The resident was observed with food and fluids in front of them with a spoon in the food. Staff were not observed to offer assistance to the resident.

A PSW confirmed the resident required assistance and prompting to eat for meals since their injury. In contrast, the RPN stated the resident did not require assistance in the dining room, just prompting and they ate well on their own.

The home not providing the resident the required assistance during meals may have lead to risk for improper nutrition and further injury to their arm.

Sources: Interview with staff, record review of the resident's care plan, observation of the resident. [706119]

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 123 (3)(a).

The licensee has failed to ensure that written policies and protocols must be, a) developed, implemented, evaluated and updated in accordance with evidenced-based practices and, if there are none in accordance with prevailing practices.

The licensee did not follow their Management of Diabetic Residents policy (NPC SM E-60) dated March 2022 when a resident had a blood sugar less than 4 mmol/L.

The licensee did not follow the MediSystem Telephone and Verbal Orders policy and procedure section 15.4.2., when a telephone order for the resident was given to the Administrator but not transcribed until two days later.

Rationale and Summary

a) The home's policy, Management of Diabetic Residents (NPC E-60) dated March 2022, stated that the hypoglycemia protocol should be initiated for any resident with a blood glucose less than 4 mmol/L. The physician was to be notified of all hypoglycemic episodes when initiating treatment for further direction/action. The hypoglycemic event was to be documented in risk management and a medication incident form completed.

On an identified date, a resident's blood sugar was less than 4 mmol/L. The RPN said they notified the RN on duty. The resident was treated with a glass of juice at the time and assisted to the dining room for their meal. After twenty minutes and fifty minutes, the resident's blood sugar was re-checked and was above 4 mmol/L. Fifty-three minutes after treating the resident for hypoglycemia, the RPN administered the resident their medication. After more than one hour, the RN on duty notified the physician of the resident's hypoglycemic event and that medication had already been administered. The physician ordered the resident a bed-time snack with protein and the resident's blood glucose be rechecked before bed.

The Director of Resident Care acknowledged that the registered staff did not follow the hypoglycemia protocol for the resident which includes holding all insulin if blood glucose is less than 4 mmol/L and notifying the physician of the hypoglycemic event to get further direction prior to administering insulin.

By staff not following the home's policy related to hypoglycemia and administering insulin to the resident when being treated for a hypoglycemic event, it put the resident at risk of having another hypoglycemic event.

Sources: resident's medication administration records, physician orders and progress notes; Management of Diabetic Residents policy (NPC E-60) dated March 2022; Hypoglycemia management policy (NPC SM f-65) dated September 2021; interviews with RPN, Director of Resident Care and Physician.

b) The MediSystem Telephone and Verbal Orders policy and procedure Section 15.4.2 stated that verbal or telephone orders must be read back to the prescriber and immediately recorded on the Prescriber's Order Form. The orders must be dated and signed with both the nurse's and prescriber's name.

The Administrator was working as a Registered Nurse and called the physician to advise them of a resident's blood sugar reading. The physician gave a telephone order to hold the resident's morning insulin and to report the supper time blood glucose to them prior to administering evening insulin.

Two days later, the Administrator recorded the telephone order received from the physician on the Prescriber's Order Form. The order was not signed with the nurse's and prescriber's name.

The Administrator acknowledged that they did not immediately record the physician's order on the Prescriber's Order Form. They also acknowledged that they did not sign the order with both the nurse's and prescriber's name.

The Administrator not documenting the telephone physician's order for the resident until two days after the telephone order was given, put the resident at risk of a hypoglycemic event and/or not receiving the appropriate dose of insulin as suggested by the physician.

Sources: resident's medication administration records, physician orders and progress notes; MediSystem Telephone and Verbal Orders policy and procedure 15.4.2; interviews with Administrator and Physician. [155]

COMPLIANCE ORDER CO#001 MEDICATION MANAGEMENT SYSTEN

NC#08 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.140.(2).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 140. (2) of O. Reg. 246/22.

The licensee shall:

a) Ensure that registered staff are providing residents #004, #006, #007, #008 and #009 medication in accordance with directions for use specified by the prescriber by completing daily audits during medication administration on the residents' home area for a two-week period following the compliance due date. A copy of the audits must be kept in the home that is accurate and complete.

b) Ensure registered staff on Collingwood 2 home area are provided a review of the flagging/alert system in the electronic Medication Administration Record and documentation is kept in the home.

c) Re-educate registered staff #114 and #124 on the home's policies for management of diabetic residents and hypoglycemic management/protocols. Documentation of this re-education is kept in the home.

d) Provide education to all registered staff in the home regarding administration of medications that have been ordered with directions for administration based on specific blood pressure and/or pulse parameters. A copy of the education provided, the date provided and names of those completing the education shall be documented and kept available in the home.

e) Develop and implement an audit to ensure that medications that are to be held based on specific blood pressure and pulse parameters, are administered to residents in accordance with the directions for use specified by the prescriber. The audit is to be completed for one month following the compliance due date. The audit record must include:

    i) When the audit was completed and the names of the people who completed the audit.
    ii) A documented summary of the audit results identifying any residents that did not receive the medications as per the blood pressure and pulse parameters as specified by the prescriber.
    iii) A documented plan of corrective action to ensure the results of the audit are corrected by the Compliance Order (CO) due date.

Grounds

The licensee has failed to ensure that drugs were administered to resident #004, #006, #007. #008 and #009 in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The Medisystem Medication Incident Report Summary and Medication Incident Reports (MIR) for the period of April 2, 2022 to May 9, 2022, showed that there had been 94 medication incidents—two omissions, one missed dose, four missed signatures and 87 medications given at the wrong time.

a) Resident #006 was prescribed a narcotic medication for pain to be administered at five specified times per day. A MIR indicated that on an identified date, resident #006 was not administered the 1400 dose of this medication until 1520 hours. Another MIR eight days later indicated that, resident #006 was not administered the 1400 dose of this medication until 1514 hours.

b) On an identified date, resident #007 was prescribed a medication to start that evening. A MIR indicated that resident #007 was not administered the medication that evening.

c) On an identified date, resident #004 was administered medication when being treated for a hypoglycemic event. There was no MIR completed for this incident.

d) Resident #004 was to be administered a medication daily but the medication was to be held if the systolic blood pressure was less than 100. Over a twenty day period, resident #004's medication was administered twice when their systolic blood pressure was less than 100 and held once when their systolic blood pressure was greater than 100. There were no MIRs completed for these incidents.

e). Resident #008 was to be administered a medication once daily when necessary (PRN) for a systolic blood pressure greater than 160 or a diastolic blood pressure greater than 95. Over a thirty day period, resident #008's recorded blood pressures indicated that they should have been administered this medication on five days, however the medication was not administered on any of these dates. There were no MIRs completed for these incidents.

f) Resident #009 was to be administered a medication two times a day but the medication was to be held if the systolic blood pressure is less than 100 or if the heart rate is less than 60. Over a eight day period, resident #009's pulse was recorded as not applicable (N/A) on two occasions and their blood pressure N/A on one occasion. The medication was administered on these occasions without the pulse and/or blood pressure. There were no MIRs completed for these incidents.

Director of Resident Care #102 and #120 acknowledged these medications were not administered as prescribed.

Resident #006 experienced pain when their medication was not administered as specified by the prescriber. Resident #004 required extra monitoring when their medication was not administered as specified by the prescriber. By not ensuring that residents #004, #007, #008

and #009 received their medications as specified by the prescriber, they were put at risk of negative health effects.

Sources: Medication Incident Reports, resident #004, #006, #007, #008, #009's progress notes, physician orders, medication administration records, medication administration audit report, Medication Administration Skills policy (NPC SM E-50 effective date December 2021) and interviews with DOC #102, DOC #120, Medical Director #115. [155]

This order must be complied with by August 17, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#001]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$5500.00,** 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

- Order #005 of 2022_773155_0001, O. Reg. 79/10 s.131.(2).

This is the first time the licensee has failed 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.*

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

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
email: 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.