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

Original Public Report

Report Issue Date: April 26, 2023

Inspection Number: 2023-1587-0005

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Corporation of the County of Simcoe

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

Lead Inspector	**Inspector Digital Signature**
Romela Villaspir (653)	Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.04.27 13:43:58 -04'00'

Additional Inspectors
Sharon Perry (155)
Gabriella Del Principe (741734)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 3-6, 11-14, 18-21, 2023.

The following intakes were completed in this Complaint inspection:

- Intake #00017348 was related to abuse and neglect, plan of care, weight changes, improper care, and continence care.
- Intake #00019034 was related to an unexpected death and falls prevention and management.
- Intake #00020461 was related to abuse, responsive behaviours, plan of care, and falls prevention and management.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake #00017379 was related to a fall resulting in injuries.

The following intakes were completed in this Follow-Up inspection:

- Intake #00084770 follow-up to Compliance Order (CO) #001 of inspection #2022-1587-0001 with a Compliance Due Date (CDD) of August 17, 2022, related to administration of drugs.

- Intake #00018220 follow-up to CO #001 of inspection #2022-1587-0002 (A1) with a CDD of September 12, 2022, related to skin and wound care.
- Intake #00085027 follow-up to CO #002 of inspection #2022-1587-0003 with a CDD of October 24, 2022, related to administration of drugs.
- Intake #00018222 follow-up to CO #001 of inspection #2022-1587-0004 with a CDD of January 27, 2023, related to administration of drugs.

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. 246/22	s. 140 (2)	2022-1587-0001	001	Sharon Perry (155)
O. Reg. 246/22	s. 55 (2) (b) (iv)	2022-1587-0002 (A1)	001	Sharon Perry (155)
O. Reg. 246/22	s. 140 (2)	2022-1587-0003	002	Sharon Perry (155)
O. Reg. 246/22	s. 140 (2)	2022-1587-0004	001	Sharon Perry (155)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to protect a resident from abuse by a co-resident.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint related to an incident of inappropriate touching.

A resident had a history of inappropriate touching, and their care plan identified interventions to prevent a recurrence.

A witness observed the resident sitting beside a co-resident in the lounge area, and the resident inappropriately touched their co-resident.

Failure to monitor the resident's responsive behaviour interventions and protect the co-resident from abuse, could have negatively impacted the co-resident's quality of life.

Sources: Residents' clinical health records, Critical Incident (CI); Interviews with the witness, the Registered Practical Nurse (RPN), and Director of Resident Care (DRC). [741734]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 97 (2)

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was notified of the results of the investigation of an incident of abuse, immediately upon the completion of the investigation.

Rationale and Summary

The results of the investigation of the abuse incident referenced in NC #001, were not provided to the co-resident's SDM, immediately upon the completion of the investigation.

By not providing the SDM with the investigation results immediately, it may have delayed any communication and decision making between the home and the SDM.

Sources: Resident's clinical health records, CI; Interview with the DRC. [741734]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident, so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

The MLTC received a complaint related to an Attending Physician (AP) not initiating end-of-life care measures for a resident, when their health condition deteriorated a week before they passed away in the home.

A resident experienced a change in their health condition and was immediately sent to the hospital for further assessment.

The resident's AP was not notified regarding a change in their health condition, within the two days following their return from the hospital. Had the AP been notified of the resident's status at that time, the AP would have collaborated with staff and the family, to assess and determine the appropriate interventions for the resident.

Sources: Resident's clinical health records; Interviews with the Personal Support Workers (PSWs), RPNs, Registered Nurse (RN), the Resident Care Program Supervisor (RCPS), AP, and the DRCs. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care for three residents, was provided to the residents as specified in the plan.

Rationale and Summary

A) A resident's plan of care specified that the scheduled medications were to be provided after a meal was eaten.

The resident's medication administration audit for a period of seven months, demonstrated a total of 34 incidents in which the scheduled medications were provided to the resident prior to meal service.

Not following the resident's plan of care specific to the timing of medication administration did not respect the resident's and SDM's choices.

Sources: Resident's clinical health records; Interview with a RPN. [741734]

B) The MLTC received a complaint related to a resident's unexpected death in the home.

At the start of the shift, a resident was found deceased in bed.

The resident's Point of Care (POC) intervention/ task required the PSWs to complete a specific intervention every hour.

During the final hour from the previous shift, a PSW did not complete the hourly intervention appropriately.

By not completing the intervention appropriately, there may have been a delay in responding to the resident, when there was a change in their condition.

Sources: Resident's clinical health records; Interviews with the PSWs, registered staff, and the DRC. [653]

C) The MLTC received a complaint related to an incident wherein a resident was found sleeping on a co-resident's bed.

A resident was known to get out of the bed on their own, and their plan of care required the placement of a device.

The RCPS indicated that the purpose of the device was to alert the staff when the resident got up from the bed.

On one occasion, an Agency PSW found the resident sleeping at the foot of a co-resident's bed. After taking the resident back to their room, the Agency PSW noted that the resident's device was not working. An Agency RN replaced the device afterwards.

By not ensuring that a functioning device was in place, the staff were not alerted when the resident got up from their bed and wandered into a co-resident's room.

Sources: Resident's clinical health records; Interviews with the PSWs, Agency RPN, Agency RN, the RCPS, and DRCs. [653]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident's plan of care for continence was implemented.

Rationale and Summary

A resident's plan of care for continence required checking the resident at specified intervals, for their continence care needs.

The resident was observed by Inspector #741734 for two and a half hours, and the resident was not checked by staff for their continence care needs, at the specified intervals.

A PSW acknowledged that the checks for the resident were not completed, despite being part of their plan of care.

By the resident not being checked for continence care needs at the specified intervals, there was a potential risk for discomfort and developing altered skin integrity.

Sources: Resident's clinical health records; Inspector #741734's observations; Interviews with a PSW and the DRC. [741734]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that strategies were implemented to respond to a resident's responsive behaviours, where possible.

Rationale and Summary

The MLTC received a complaint related to an allegation of a resident abuse.

A resident was at risk for falls and was known to have responsive behaviours. The resident's care plan identified interventions on how to monitor the resident and manage their responsive behaviours.

On one occasion, the resident was exhibiting responsive behaviours, and a staff member implemented a strategy that was not aligned with their plan of care.

A PSW observed the strategy being implemented and informed another PSW that this strategy was inappropriate for the resident's care.

The staff member acknowledged that they would sometimes implement this strategy when the resident exhibited responsive behaviours.

By not implementing the appropriate strategies as per the resident's plan of care, there was a potential risk for the resident to exhibit more responsive behaviours, which could potentially result in the resident getting injured.

Sources: Resident's clinical health records, the home's investigation notes; Interviews with the PSWs, RN, the DRCs, and other staff. [653]

WRITTEN NOTIFICATION: TRAINING AND ORIENTATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that training on falls prevention and management was provided to an Agency PSW.

Rationale and Summary

During care, a resident had a fall which resulted in injuries.

The Agency PSW who was present at the time of the fall, stated that they had been working at the home for about ten months, and they have not received training on falls prevention and management.

By not providing training on falls prevention and management to the Agency PSW who was a direct care staff, there was a potential risk that the Agency PSW may not integrate falls prevention approaches, strategies, and interventions when providing care to the residents.

Sources: Resident's clinical health records, CI report; Interviews with the Agency PSW, RPN, and the DRCs. [653]

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Follow-Up #00084770 r/t to FLTCA, 2021, s. 104 (4) - O. Reg. 246/22 - s. 140 (2) r/t Administration of Drugs from #2022_1587_0001.

Follow-Up #00018220 r/t FLTCA, 2021, s. 104 (4) - O. Reg. 246/22 - s. 55 (2) (b) (iv) r/t Skin and Wound Care from #2022_1587_0002.

Follow-Up #00085027 r/t FLTCA, 2021, s. 104 (4) - O. Reg. 246/22 - s. 140 (2) r/t Administration of Drugs from #2022_1587_0003.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.