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

Original Public Report

Report Issue Date: July 28, 2023

Inspection Number: 2023-1587-0006

Inspection Type:
Complaint
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**
Katherine Adamski (#753)	Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.08.01 14:05:37 -04'00'

Additional Inspector(s)
Craig Michie (#000690)
Amanpreet Kaur Malhi (#741128)
Alicia Campbell (#741126)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 6-7, 10-14, 18, 2023.

The following Critical Incident intakes were inspected:

- Intake: #00086547, #00017976, #00019929 - related to prevention of abuse and neglect
- Intake: #00001513 - related to an unexpected death of a resident
- Intake: #00084023 - related to improper care and treatment
- Intake: #00088583 - related to improper transfers
- Intake: #00090218 - related to fall prevention and management

The following complaint intake was inspected:

- Intake: #00017655 - related to skin and wound prevention and management

The following intakes were completed in this inspection: intake #00088083, #00085872, #00085727, #00021938 - related to falls prevention and management.

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

Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

A resident required a specific type of equipment for transfers and this was not documented accurately in their plan of care.

The Director of Care (DOC) acknowledged that the information was not accurate and made the required changes to their plan of care.

Sources: Observations, a resident's plan of care, interviews the staff.

Date Remedy Implemented: July 18, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee failed to ensure that the outcomes of the care set out in the plan of care for a resident were documented.

Rationale and Summary

A resident required assistance from staff related to their continence and evening care.

The resident had refused care and staff did not communicate or document the refusal as required; therefore, the resident did not receive continence and evening care.

Sources: the home's investigative notes, a resident's plan of care, interviews with staff. [#753]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Rationale and Summary

A resident required specific transferring techniques to ensure their safety.

The resident was transferred using a transfer technique they had not been assessed for and was not specified in their care plan. Additionally, staff did not transfer the resident as per the home's Minimal Lift Program Policy.

When staff did not use safe techniques to transfer the resident, the resident fell and was injured.

Sources: the home's internal investigation, residents plan of care, Minimal Lift Program Policy, interviews with the resident's Substitute Decision Maker (SDM) and staff. [#753, #741126]

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that as needed (PRN) pain medications were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident had orders for scheduled and PRN medication for pain management.

The resident was injured, and scheduled pain medication was provided, but not effective. The resident's pain increased, and more pain medication was requested. The PRN pain medication was not administered.

When PRN pain medication was not administered to the resident for increasing pain, this may have prolonged their suffering.

Sources: A resident's plan of care, interview with the resident's SDM and staff. [#753, #741128]