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: May 9, 2024

Inspection Number: 2024-1587-0001

Inspection Type:
Complaint
Critical Incident

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**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.05.09 12:55:56 -04'00'

Additional Inspector(s)
Tanya Murray (000735)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23 - 26, 29 - 30 and May 1 - 2, 2024

The following intake(s) were inspected:

- Intake: #00108699 - Resident to resident alleged abuse
- Intake: #00110636 - Complaint related to neglect of a resident
- Intake: #00111420 - Related to an outbreak
- Intake: #00111633 - Complaint related to neglect of residents
- Intake: #00112869 - Related to an outbreak

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 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

The licensee failed to ensure that behavioural strategies were implemented when a resident was demonstrating responsive behaviours.

Rationale and Summary:

A resident had a history of responsive behaviours.

Their plan of care contained strategies to manage the responsive behaviours.

The resident was observed to have responsive behaviors toward another resident. Strategies to manage their behavior were not implemented according to staff.

Failure to implement the strategies for responsive behaviours put staff and residents at risk of harm.

Sources. risk management, observations, plan of care, progress notes. interview with RPN #116.
[659]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control is followed.

Specifically, the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states that at minimum, additional precautions shall include additional

personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Rationale and Summary:

A) A Personal Support Worker (PSW) was observed in a resident's room not wearing specified PPE while completing care. The staff member left the room without doffing the PPE.

The IPAC lead confirmed that staff should be wearing specified PPE when completing any care that involves contact with the resident when on contact precautions as per the signage outside the room.

The home's additional precautions policy indicated that staff are to wear gown and gloves to reduce the risk of transmitting infectious agents via contact with an infectious person when contact precautions are in place.

Failure to ensure that staff wear the correct PPE in accordance with routine practices and additional precautions could lead to the spread of infections.

Sources: observations on April 24, 2024, IPAC Standard, Additional Precautions policy, and interviews.
[000735]

B) A resident was on additional precautions. Signage outside their door directed staff to additional precautions required which included applying specified PPE prior to providing care. A stocked caddy with supplies was outside the resident's room.

Two PSWs were observed to enter the resident's room. Neither PSW followed the

signage directions for additional precautions.

Failure to follow additional precautions for infection prevention and control puts both residents and staff at risk due to potential transmission of infectious pathogens.

Sources: observations, IPAC standard, Additional Precautions policy and interviews. [659]