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
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Public Report

Report Issue Date: January 6, 2025
Inspection Number: 2024-1587-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19-22, 25-29, 2024 and December 2-5, 2024.

The following intake(s) were inspected:

- Intake: #00125574, related to responsive behaviours and prevention of abuse and neglect.
- Intake: #00126842, related to infection prevention and control.
- Intake: #00127233, related to prevention of abuse and neglect.
- Intake: #00129567, related to resident care and support services.
- Intake: #00130146, related to responsive behaviours and the prevention of abuse and neglect.
- Intake: #00131191, related to infection prevention and control.
- Intake: #00127585, a complainant related to medication management.
- Intake: #00132407, a complainant related to medication management.
- Intake: #00131437, a complaint related to skin and wound care management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

(A) The licensee has failed to ensure that the physician was made aware of the resident's medical complication to develop and implement a collaborative plan of care.

Rationale and Summary
The resident had medical directives ordered to initiate protocols when their blood sugar (BS) levels were low.

There was no documentation of the physician being informed when the resident's

BS readings were below the level identified in the medical directives.

The home's policy regarding this medical complication stated that if initiating treatment, the physician was to be informed. The physician stated that they were not informed.

Failure to ensure that the physician was informed was a missed opportunity to adjust the resident's medications.

Sources: Interview with physician, The resident's clinical notes, Home's policy.

(B) The licensee has failed to ensure that the physician was made aware of the residents medical complication to develop and implement a collaborative plan of care.

Rationale and Summary
An additional resident had medical directives ordered to initiate protocols when their blood sugar (BS) levels were low.

There was no documentation of the physician being informed when the resident's BS reading was below the level identified in the medical directives.

The home's policy regarding this medical complication stated that if initiating treatment, the physician was to be informed. The physician stated that they were not informed.

Failure to ensure that the physician was informed was a missed opportunity to adjust the resident's medications.

Sources: Interview with physician, the resident's clinical notes, Home's policy.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The home failed to ensure that the staff complied with the residents plan of care.

The residents plan of care included directions to not have cardiopulmonary resuscitation (CPR) in the event that their heart stops. Documentation for this was completed and available in the resident's chart.

The resident was found unresponsive and vital signs were absent. A registered staff member-initiated CPR after reviewing outdated directions in the chart.

When staff fail to comply with a resident's plan of care, undesirable interventions provided may cause harm to the resident.

Sources: Resident’s clinical chart, home's internal investigation, interviews with staff.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure that interventions were initiated for a resident were documented.

Rationale and Summary
The resident had medical directives ordered to initiate protocols when their BS was low.

It was documented that the resident had low BS and there was no documentation of protocols being followed. A registered staff member stated that the resident was provided with orange juice to manage the medical complication.

The DRC stated that the actions taken to manage the medical complication must be documented.

Failure to document actions taken to manage the medical complication decreases opportunity for evaluating effective and ineffective interventions to manage abnormal BS levels.

Sources: The residents clinical notes, Interviews with staff.

B) The licensee has failed to ensure that interventions were initiated for a resident were documented.

Rationale and Summary
An additional resident had medical directives ordered to initiate protocols when their BS was low.
On one occasion it was documented that the resident had a low BS level and there was no documentation of protocols being followed. A registered nurse stated that the resident was provided orange juice to manage the medical complication.

On another occasion the resident had a low BS level and there was no

documentation of protocols being followed. Registered nurse stated that the resident was provided orange juice to manage the medical complication.

DRC stated that actions taken to manage the medical complication must be documented.

Failure to document actions taken to manage the medical complication decreases opportunity for evaluating effective and ineffective interventions to manage abnormal BS levels.

Sources: The residents clinical notes, Interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

(A) The licensee has failed to document the outcome of the resident's BS monitoring.

Rationale and Summary
The resident was scheduled to have their BS checked on multiple occasions.

On two dates only two BS levels were documented on PointClickCare (PCC) and on five occasions the BS levels were taken however were not documented.

The DRC stated that all BS levels should be documented in PCC.

Failure to document all BS level readings decreases opportunity for evaluating effective and ineffective interventions to manage BS levels.

Sources: The residents clinical records, The residents Glucometer, Interview with DRC

(B) 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
The resident had a new order for a respiratory medical intervention.

A review of the resident's clinical records indicated that there was no documentation of the implementation of the intervention on the second and third day after the order was initiated.

On the fourth day the resident had a new order for a respiratory medical intervention.

A review of the resident's clinical records indicated that the intervention was only documented twice. The documentation of the outcome of the intervention on the other dates were absent.
The DRC acknowledged that the outcomes of the intervention, as directed by the physicians orders in the plan of care should have been documented.

By not documenting the outcomes of the respiratory medical intervention there may have been risk to the resident.

Sources: The residents clinical records, physicians orders, progress notes, Oxygen saturation measurements, interview with DRC.

WRITTEN NOTIFICATION: Duty to protect

NC #005 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.

The licensee has failed to ensure that a resident was protected from abuse from another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A review of both residents clinical records indicate that the resident approached the other residents door. The resident knocked on the door and then opened the door. The other resident then pushed the resident who knocked and opened the door causing them to fall backwards onto the floor.

The resident who fell backwards onto the floor sustained an injury.

Two Personal Support Workers (PSW) observed the incident.

By failing to protect the resident from abuse, the resident was physically injured.

Sources: CIS Report, both resident's clinical records, Interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that anyone who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident is immediately reported to the Director.

Rationale and Summary
The resident fell and sustained a new area of altered skin integrity when two PSW's were attempting to redirect the resident to their room.

Both PSW's reported this to the nurse after the incident happened.

The LTCH did not report this incident to the Director until the next day.

Not immediately reporting the incident to the Director did not allow the Ministry of Long-term Care an opportunity to follow-up.

Sources: Interviews with staff, CIS report.

WRITTEN NOTIFICATION: Skin and Wound Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

The licensee has failed to ensure that the skin and wound care program was followed, and that residents were provided treatments and interventions as directed.

Rationale and Summary
(A) The resident did not have the correct treatment implemented for an area of altered skin integrity, as per the home's wound care standardized treatment protocols. As well, a RPN initiated treatment that is required to be prescribed by a nurse practitioner (NP) or physician.

The Treatment Administration Record (TAR) for the resident indicated for a medicated dressing to be applied to the wound. This was the incorrect treatment based on the home's wound care standardized treatment protocols.

A RPN confirmed that this medicated dressing for wound care must be prescribed by a NP or physician.

(B) A different resident had an area of altered skin integrity on their lower back. The physician order indicated that a non-medicated dressing was to be applied.

The skin and wound assessments for the resident on multiple dates indicated that the dressing had not been applied to the area as prescribed. The documentation indicated that either no dressing had been applied or "other" had been indicated under dressing type.

The physician documented in the resident's progress notes on three occasions, that a dressing was not in place when the resident was assessed.

(C) The physician documented for another resident, that on multiple dates the dressing was not in place for an area of altered skin integrity on the resident.

On one occasion, the skin and wound evaluation indicated that the dressing had not been applied as per the physician's orders. Two days later when the wound assessment was completed, the wound had deteriorated.

A non-medicated dressing had been ordered, but documentation showed other dressings were used or no dressing had been applied on multiple dates. On another occasion, a dressing was not applied and the PSW's documentation was signed that the dressing was present on the wound.

(D) An additional resident had a new area of altered skin integrity identified. The order for this area of altered skin integrity was entered into the TAR incorrectly for nearly two years until staff noticed that this was the wrong type of dressing for this wound and corrected the order.

A RPN confirmed that the area of altered skin integrity was documented incorrectly in one Skin and Wound Assessment.

(E) The resident did not have treatment for their wound provided as per the directions in the physician order. The order indicated that the registered staff were to provide wound care as needed after each episode of incontinence/perineal care.

The resident's clinical records indicated that the resident was frequently incontinent of urine, but only on three occasions was care documented on the TAR by registered staff as being provided. A PSW confirmed that the resident is always incontinent of urine, and the PSW's applied barrier cream after incontinence care. The resident was getting a bandage with betadine, but not any longer. PSW confirmed they would call the nurse after resident being incontinent, and if the area was red or worse.

A RPN confirmed that the resident was incontinent at times. The PSW's are not notifying the registered staff if the resident is incontinent to complete treatment as ordered. A RPN confirmed they often come in during resident care to complete the wound assessment, and the resident was always soiled, At that time, they would complete the treatment and document under as needed on the TAR. The RPN confirmed that staff should be signing for it when it was applied. The RPN confirmed after reviewing the TAR, that the staff may not have provided care at other times during the day as directed in physician's order.

Failure to have treatment implemented as per directions could slow the healing of the wound.

Sources: The resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that accurate skin and wound evaluations were completed for residents with impaired skin integrity.

Rationale and Summary
(A) A resident had a wound upon admission. The incorrect location of the wound was entered in the skin and wound assessment. Sometime later, the description of the wound location was changed to a different area. The wound healed. Then a new wound was documented in the skin and wound assessment. Several wounds were assessed and documented for previous wounds on various dates.

The RPN confirmed that when a new skin and wound assessment is initiated for a wound, it should be given a different wound number. Another RPN also confirmed that each new wound should have a different number, and that some of the resident's wounds were labelled wrong. One wound had been documented under the wrong assessment, and possibly the wrong pictures had been entered by the staff as the resident had multiple wounds at the time. The RPN felt that the nurses were measuring different areas for the same wound.

(B) A resident had a new pressure injury. Several months later, the wound had deteriorated and was documented as a stage 4 pressure injury, with undermining present. The physician had been documenting the measurements of the wound almost monthly and indicated that the wound had undermining and/or tunneling on every assessment.

No undermining or tunneling had not been documented on many of the wound assessments completed by the registered staff once the wound had deteriorated.

The physician noted that there was no packing in the wound during one assessment, and sometimes incorrectly placed. The NP confirmed that a tunnel in a wound is often slow to heal and felt that tunneling and undermining could often be confused. The NP confirmed that it could have been missed or not properly documented in the assessment.

(C) A resident had a wound. The physician's measurements included undermining in several areas of the wound and found two pieces of packing present in wound. The physician indicated that the packing should be placed in a single piece to prevent inadvertent retention of dressing materials.
Tunneling was identified and documented in the skin and wound assessment and had not been documented again until several months later for the wound, although the physician's progress notes indicated that tunneling was present.

Multiple residents potentially had inaccurate evaluations when comparing with the physician's assessments who has training in wound care, and errors were not corrected until months later for the correct numbering of wounds and their locations.

Failure to complete accurate skin and wound assessments could lead to incorrect treatment and make it difficult to monitor the status and age of a wound.

Sources: The resident's clinical records, interviews with staff, skin care program policy

WRITTEN NOTIFICATION: Skin and Wound Management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee failed to ensure the supplies referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Rationale and Summary
(A) The resident had a wound. The physician's orders for wound care indicated to use a specific dressing.

11 days later, the physicians note indicated that the dressing was still not on hand for wound care. A second order indicated that if no dressing was available, to use another dressing temporarily. The dressing should be secured with film to prevent contamination of the wound. The dressing was found by the physician with no film in place. On multiple dates, the physician indicated that the incorrect supplies were used, or that recommended supplies were not available to properly complete wound care.

(B) A different resident had a wound. The physician's note indicated that the dressing was not available on the cart. The dressing that was applied left part of the wound exposed. The physician explained to the nurse that it was the incorrect dressing for the wound.

(C) Another resident acquired a new area of altered skin integrity. The physician documented that the resident did not have the correct treatment.

The RPN confirmed that the treatment the resident received for altered skin integrity was not recommended as per home's wound care standardized treatment

protocols.

Failure to implement the correct treatment for the residents could cause further skin integrity issues.

Sources: The resident's clinical records, interview with staff, and wound care standardized treatment protocols.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that strategies for managing responsive behaviours for a resident were written in the resident's care plan.

Rationale and Summary
In accordance with O.Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that residents' responsive behaviour triggers and strategies are included in the resident's care plan.

The resident hit a co-resident on the arm after co-resident had asked them to move from in front of the TV. The resident had a history of responsive behaviours. A PSW and RPN stated that the resident did not like loud noises and would sometimes stand in front of the TV to provoke co-resident. Staff indicated that they would

redirect the resident to a quiet place to manage their responsive behaviours. Resident Care Program Supervisor also indicated that music was a strategy that staff would use to calm the resident. These strategies were not written in the resident's care plan.

By not ensuring the policy was followed and the written strategies to prevent, minimize or respond to the responsive behaviours were in the care plan, all staff would not be aware of the strategies in place to manage the resident's responsive behaviours.

Sources: Interviews with staff, Responsive Behaviours Care Monitoring Policy, Responsive Behaviours Huddle assessment, the resident's care plan.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 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).

In accordance with the IPAC Standard last revised September 2023, the section titled Additional Requirements 4.3 states: the licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary
The IPAC Lead acknowledged that the OMT did not conduct a debrief session in October or November 2024 to assess IPAC practices that were effective and ineffective in the management of the outbreak that ended in October 2024.

Failure of the home to conduct the debrief session once the outbreak was declared over to discuss and identify processes that worked well and areas for improvement, placed the residents and the staff at risk of further spread of infections.

Sources: CIS Report, Outbreak Management Policy, IPAC Outbreak Debrief Meeting Minutes, Interview with IPAC Lead.

WRITTEN NOTIFICATION: Medication management system

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to ensure that the resident had an independent second check ordered every time insulin was to be administered.

In accordance with O. Reg 246/22 s. 123 (3)(a), the licensee is required to ensure that there is a medication management system that provides safe medication management.

Specifically, the licensee did not comply with their policy "High Alert Medication - Independent Double Checks," which stated that high alert medications including

insulin required an independent second check.

Rationale and Summary
The home's policy "High Alert Medication - Independent Double Checks," stated that high alert medications including insulin required an independent second check to ensure that risks to residents are reduced.

The resident had medication scheduled three times a day. Starting on a specific date, independent second checks were only scheduled twice.

The DRC stated that there should be an independent second check for each administration as per the home's policy.
Failure to have an independent second check for each administration increased the risk for a medication error.

Sources: Interview with DRC, the residents clinical records, Policy titled "High Alert Medication - Independent Double Checks"

WRITTEN NOTIFICATION: Administration of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

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Rationale and Summary
The resident had a new standing order for a respiratory medical intervention which directed staff to notify the Medical Director (MD) if the resident’s condition continued for greater than 24hrs.

A review of the residents clinical records indicated that the resident was administered a respiratory medical intervention however, the MD was not informed until 5 days later.

The DRC acknowledged that the MD should have been informed.

By not following the prescriber's directions for the administration of the respiratory medical intervention the prescriber was not able to assess in a timely manner.

Sources: The resident’s clinical records, physician’s orders, progress notes, MD book, interview with DRC.