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

Public Report

Report Issue Date: February 14, 2025

Inspection Number: 2025-1587-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3 - 7, 11 - 14, 2025

The following intake(s) were inspected:

- Intake #00132449 - Complaint alleging neglect and concerns with bowel management.
- Intake #00134866 - CI M581-000077-24 related to alleged neglect with continence care.
- Intake #00135659 - CI M581-000080-24 related to alleged resident to resident abuse.
- Intake #00135095 - CI M581-000001-25 related to an outbreak.
- Intake: #00137367 - CI M581-000003-25 related to alleged resident to resident abuse.

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

Continence Care

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident had the assistance required to change their brief when it became soiled. The resident requested help from staff to change their brief and did not receive assistance right away to remain clean and dry. The resident was left in the soiled brief for about 45 minutes before receiving assistance from staff.

Sources: Interviews with PSW#109 and RN #107, Progress Notes, Investigation Notes.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 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 failed to ensure that strategies and interventions for managing responsive behaviours were on a resident's care plan to ensure the safety of staff and residents.

A resident was inappropriate with a co-resident. Two code whites were called that evening to manage responsive behaviours.

Sources: Resident's care plan, interview with DRC #115, and Responsive Behaviour Policy.