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: April 28, 2025

Inspection Number: 2025-1587-0002

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): April 10, 11, 15, 16, 17, 22, 23, 24, 25, 28, 2025

The following Critical Incidents (CI) intakes were inspected:

- Intake: #00139252- Enteric unknown Outbreak
- Intake: #00139903, Intake: #00141858 and Intake: #0014218 - Unwitnessed fall resulted in an injury
- Intake: #00140188 and Intake: #00141644- Physical abuse resident to resident

The following Complaint intakes were completed in this inspection:

- Intake: #00140904 - related to mice infestation concerns.
- Intake: #00138945 - related to Skin and Wound Care concerns

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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.

The licensee failed to ensure that the provision of care set out in resident's plan of care was completed as specified in the plan.

Staff submitted inaccurate documentation indicating that a resident's care was completed, however, it was found not to be done.

Sources: Review of POC documentation and TAR documentation for residents and interview with staff.

The licensee has failed to ensure the provision of care set out in the plan of care for a resident was documented accurately.

Staff documentation indicated that a resident had received care, upon further review, the resident did not receive the care as it was resolved for quite some times.

Staff confirmed that the treatment for the resident should have been discontinued after it was resolved.

Sources: Resident's clinical health records, Observation and interview with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to update a resident's care plan with falls interventions following multiple falls from self-transferring. No interventions had been implemented on the care plan when care was ineffective until after the second injury.

Failure to implement falls interventions for the resident may have contributed to subsequent falls and injury.

Sources: Resident's progress notes, care plan, assessments, and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that accurate weekly re-assessments of skin and wound evaluations were completed for residents with impaired skin integrity.

Weekly skin assessments include measurements of undermining and tunneling, evaluation of wound discharge, and documentation of any changes in the wound's condition. This information is required to monitor the progress of the wound and determine if further action is required. On multiple occasions, the weekly skin assessments were not fully completed for some residents.

Skin and wound evaluations must be completed in full for all wounds during weekly assessment. Without measurements for undermining and tunneling, the wound's full condition cannot be accurately assessed and these measurements indicate whether the wound is improving or deteriorating.

Sources: Residents clinical records; interview with staff; skin care program policy #NPC D-30; How to pack a wound procedure; and Wound Management Program Policy #NPC D-35