Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 9, 2021 | 2021_729615_0009 | 019389-20, 001510-21, 002555-21 | Critical Incident System |

### Licensee/Titulaire de permis

The Corporation of the County of Essex
360 Fairview Ave West Essex ON N8M 1Y6

### Long-Term Care Home/Foyer de soins de longue durée

Sun Parlor Home for Senior Citizens
175 Talbot Street East Leamington ON N8H 1L9

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

HELENE DESABRAIS (615)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 1, 2 and 3, 2021.**

**The following intakes were inspected during this inspection:**

**Log #001510-21/Critical Incident System report #M579-000002-21 related to falls prevention;**
**Log #002555-21/Critical Incident System report #M579-000004-21 related to responsive behaviours and prevention of abuse, neglect and retaliation;**
**Log #019389-20, Follow Up to Compliance Order #001 from inspection #2020_563670_0027 related to following the home's falls policies.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, an Assistant Director of care, the Registered Nurse Infection Prevention and Control Lead, a Registered Practical Nurse, two Personal Support Workers and a housekeeper.**

**The inspector also toured the home, observed Infection Prevention and Control practices, residents and the care provided to them, reviewed residents' clinical records and other relevant documents.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 8. (1) | CO #001 | 2020_563670_0027 | 615 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure drugs that were stored in a medication cart was secured and locked.

During a tour of the home, the Inspector entered a home unit and observed a medication cart left in the hallway at the entrance of the dining room with residents wandering by the unlocked medication cart. The Inspector was able to open all the drawers of the medication cart and look inside where drugs were stored. The Inspector asked a Personal Support Worker (PSW) where the nurse was and they could not locate them. The Registered Practical Nurse (RPN) returned to the medication cart and confirmed they had left the cart unlocked and unattended and should have locked it. During an interview, the Director of Care (DOC) stated that the expectation was that registered staff lock the medication cart when unattended. The unlocked and unattended medication cart posed a risk of harm to residents.

Sources: observations and interviews with a RPN, the DOC and other staff. [s. 129. (1) (a) (ii)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure drugs that are stored in a medication cart are secured and locked, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, reported the alleged abuse immediately to the Director. Pursuant to s.152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A review of a resident's progress notes and the home's Critical Incident Report indicated that an alleged abuse occurred on a specific date and was reported to the Director a day later. During an interview, the Director of Care stated that the expectation was that alleged abuse be immediately reported to the Director.

Sources: Home's Critical Incident Report, a resident's progress notes, interviews with the DOC and other staff. [s. 24. (1)]

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**Issued on this 10th day of March, 2021**

**Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs**

**Original report signed by the inspector.**