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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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
Aug 31, 2021	2021_563670_0021	010465-21, 010518-21	Complaint

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

DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 23, 24, 25, 26 and 30, 2021.

The purpose of this inspection was to inspect the following:
-Log# 010518-21 IL-91668-LO complaint related to alleged staff to resident abuse.
-Log# 010465-21 CIS# M579-000019-21 related to alleged staff to resident abuse.
Inspector #725 was present for this inspection.
Inspection #2021_563670_0022 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Care, one Assistant Director of Nursing Care, one Assistant Director of Care Infection Prevention and Control Lead, one Environmental Services Manager, three Registered Nurses, four Personal Support Workers, one Housekeeper, one Visitor/Witness and residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance in the home, observed Infection Prevention and Control Practices in the home, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records and reviewed relevant internal documentation.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

The home submitted Critical Incident System report (CIS) alleging staff to resident abuse.

Review of the home's investigation notes showed that a witness had reported to the home that they had witnessed and incident. A staff member of the home received specific interventions related to the witnessed incident.

During an interview with the witness they stated that they had witnessed a specific incident and had reported this to the home.

During an interview with Director of Nursing Care (DNC) they stated that after the home had completed their investigation a staff member had received specific interventions related to the reported incident.

The homes failure to protect a specific resident from abuse placed the resident at risk for harm.

Sources: CIS#M579-000019-21, internal investigation notes, interview with a witness and interview with the DNC. [s. 19. (1)]

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 that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 31st day of August, 2021

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

Original report signed by the inspector.