Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
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Original Public Report

Report Issue Date July 4, 2022
Inspection Number 2022_1586_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Essex

Long-Term Care Home and City
Sun Parlor Home for Senior Citizens
Leamington, ON

Lead Inspector
Julie D'Alessandro (739)

Inspector Digital Signature
Julie D'Alessandro
2022.07.04 15:32:40 -04'00'

Additional Inspector(s)
Stephanie Morrison (721442)
Terri Daly (115)
Inspectors Karen Honey (740899), Andrea Dickinson (740895), and Carole Ma (741725) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 15-17, 20, 22, and 23, 2022.

The following intake(s) were inspected:
- Log #003894-22/CI #M579-000008-22 related to falls prevention and management
- Log #005249-22/CI #M579-000009-22 related to a change in resident status

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102(2)(b)

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) was implemented by not having followed the IPAC Standard for Long-Term Care Homes, April 2022, regarding hand hygiene and additional precaution signage.

Rationale and Summary
A) IPAC Standard Section 10.4 on the home's Hand Hygiene Program referenced the Public Health of Ontario's Just Clean Your Hands program, which specified the four moments of hand hygiene are 1) before initial resident/resident environment contact, 2) before any aseptic procedure, 3) after bodily fluid exposure risk, and 4) after resident/resident environment contact.
It was observed that a Personal Support Worker (PSW) did not complete hand hygiene before and after coming into contact with multiple residents and resident environments on a unit. The PSW completed physical assistance to several residents without completing hand hygiene before or after. The PSW recognized they should have completed hand hygiene between each resident interaction. The IPAC Lead confirmed not having completed hand hygiene between each of the resident interactions had not met the expectations of the home's IPAC program.

Another PSW removed a lunch tray from a resident's room on a different unit. The PSW took the tray to the dining room to empty the dirty dishes but did not complete hand hygiene after emptying the dirty dishes and before entering a different resident's room. The PSW acknowledged that they should have completed hand hygiene after emptying the tray of dirty dishes and entering the other resident's room.

B) IPAC Standard Section 10.4 on the home's Hand Hygiene Program stated residents are to be offered support to complete hand hygiene prior to receiving meals.
It was observed that hand hygiene was not offered for multiple residents on a unit prior to being served their lunch meal. Two PSW's stated hot towels with lemon water were offered to residents after meals, but not before since the home was no longer in outbreak. The IPAC Lead confirmed the expectation was all residents would be offered support with hand hygiene with hand sanitizer prior to meals regardless of the home's outbreak status.

C) IPAC Standard Section 9.1 on Routine Practices and Additional Precautions stated the licensee must ensure that point-of-care signage indicating enhanced IPAC control measures were in place.
A resident required a medical treatment, which required droplet/contact precautions while the treatment was in use. The required additional precautions, as per the home's IPAC program, included several types of personal protective equipment (PPE). A sign was on the resident's door which identified one type of PPE required and a second sign was in place specifying staff

were to use re-useable gowns. The signage did not indicate whether two other types of PPE were required during the treatment. A Registered Nurse (RN) confirmed the staff were required to wear four different types of PPE when in the resident's room to provide the medical treatment. The IPAC Lead and Director of Nursing (DON) agreed clear signage should have been on the resident's door which indicated the required additional precautions.
The home not having followed the IPAC Standard for hand hygiene and additional precaution signage increased the risk of the spread of communicable disease, including COVID-19.

Sources: Observations of the home's IPAC practices, Review of the IPAC Standard for Long-Term Care Homes, April 2022; and Interviews with PSW's, a RN, IPAC Lead, and the DON. [721442]

WRITTEN NOTIFICATION [HAZARDOUS SUBSTANCES]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 97

The licensee had failed to ensure all hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary
A bathing suite door was observed to have been left open on a unit. The Disinfectant Cleaner with a toxic and corrosive warning label was accessible to residents. A PSW stated the bathing suite door should have been closed.

The bathing suite door having been left open allowed residents access to a hazardous substance, which had the potential risk to cause harm to one or more residents.

Sources: Observations and an interview with a PSW.
[721442]

WRITTEN NOTIFICATION [MEDICATION ADMINISTRATION]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 114 (2).

The licensee had failed to comply with the policy to initial a medication as administered on the Medication Administration Record (MAR) for a resident.

Rationale and Summary
In accordance with O.Reg 79/10 s.8(1)b the licensee was required to ensure that the home had a medication management policy, and that the policy was complied with.

Specifically, a RN administered a medication to a resident and did not initial the administration on the resident's MAR.

A progress note indicated in part that, the resident's level of consciousness had decreased from their baseline. The RN pulled a medication from emergency stock, as per the physician's order, and administered the medication to the resident.

The home's Policy titled, "Administering Routine Medications" 4.2, stated in part that, each individual medication was to be initialed as administered, on the MAR, upon administration.

Record review of the resident's electronic medication administration record (eMAR) had not included an initial for the administration of the medication by the RN.

During an interview with the RN they stated that, they believed they had forgotten to document in the eMAR with their electronic signature but they had completed a progress note.

During an interview with an Assistant Director of Nursing (ADON) they stated that the expectation would have been that the RN initialed the medication on the eMAR when it was administered to the resident.

Sources: Interview with the RN and ADON, the resident's eMAR, the home's policy for Administering Routine Medications

[739]