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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 23, 2024
Inspection Number: 2024-1586-0003
Inspection Type: Critical Incident
Licensee: The Corporation of the County of Essex
Long Term Care Home and City: Sun Parlor Home for Senior Citizens, Leamington

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 13-16, 2024

The following critical incident intakes were inspected:

- Intake #00109116 related to alleged resident to resident abuse
- Intake #00115148 related to parainfluenza outbreak
- Intake #00116891 related to alleged resident to resident abuse
- Intake #00119892 related to falls prevention and management

The following critical incident intake was completed in this inspection:

- Intake #00121222 related to falls prevention and management

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

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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Introduction:
The licensee failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary:
A resident had responsive behaviours identified in their plan of care. An intervention for the responsive behaviours was documented in the resident's plan of care.

At the time of the incident, the intervention documented in the resident's plan of care was not used by staff. During this time the responsive behaviours occurred.

Assistant Director of Care stated that the expectation would have been that staff should have used the intervention as per the plan of care and acknowledged that they did not.

Not following the resident's plan of care put other residents at risk for their responsive behaviours.

Sources: Resident's plan of care and staff interviews.