

**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

**Public Report**

<b>Report Issue Date:</b> September 24, 2025
<b>Inspection Number:</b> 2025-1586-0003
<b>Inspection Type:</b> Critical Incident
<b>Licensee:</b> The Corporation of the County of Essex
<b>Long Term Care Home and City:</b> Sun Parlor Home for Senior Citizens, Leamington

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): September 15 - 19 and 22 - 24, 2025

The following intake(s) were inspected:

- Intake: #00155564 -Critical Incident (CI) M579-000028-25 - relating to an unexpected death of a resident.
- Intake: #00155570 -CI M579-000029-25 - relating to allegations of incompetent care and treatment of a resident.
- Intake: #00155779 -CI M579-000030-25 - relating to an incident of resident to resident responsive behaviours.

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

- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Responsive Behaviours

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to protect

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

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (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.

The licensee failed to protect a resident from neglect by a staff member.

O. Regs. 246/22, 7. For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A staff member did not provide a resident with care and follow up as required resulting in an injury.

Sources: Resident records, staff interviews and internal investigation notes.

### WRITTEN NOTIFICATION: Notification re incidents

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

**Non-compliance with: O. Reg. 246/22, s. 104 (2)**

Notification re incidents

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s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to inform a resident and their Substitute Decision-Maker (SDM) of the outcome of an investigation. An investigation had been completed for an incident of neglect that had involved the resident and when the investigation had concluded the outcome was not shared with either the resident or their SDM.

Sources: Resident records, internal investigation notes and interviews.