



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée

Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch

London Service Area Office  
291 King Street, 4th Floor  
LONDON, ON, N6B-1R8  
Telephone: (519) 675-7680  
Facsimile: (519) 675-7685

Bureau régional de services de  
London  
291, rue King, 4<sup>ième</sup> étage  
LONDON, ON, N6B-1R8  
Téléphone: (519) 675-7680  
Télécopieur: (519) 675-7685

Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité

**Public Copy/Copie du public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2014	2014_257518_0003	L-001038-13	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**

ALISON FALKINGHAM (518)

**Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): January 23-24, 28-29, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager or Resident/Family Support Services, Human Resources, Accounts Payable, Administrative Assistant, two Registered staff and four Personal Support Workers.**

**During the course of the inspection, the inspector(s) reviewed a residents health record, the homes internal investigation, the homes policies and procedures, annual education materials and attendance, staff attendance records, a resident financial audit, and a written submission by the Public Guardian and Trustee.**

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

**Findings of Non-Compliance were found during this inspection.**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: 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).**

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**Findings/Faits saillants :**

1. The licensee had reasonable grounds to suspect financial abuse and did not immediately report this suspicion to the Director.  
On September 12, 2012 a staff member was reimbursed for unauthorized expenses with out receipts by Accounts Payable on the direction of a Manager. This should have been reported to the Administrator of the Home and the Director at that time. This is not the homes policy or regular practice as confirmed by the Administrator, the Manager and Accounts Payable . [S. 24. (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 related to a person who has reasonable grounds to suspect that abuse has or may occur shall immediately report the suspicion and the information on which it is based to the Director., 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. 19. Duty to protect**



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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).**

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**Findings/Faits saillants :**

1. The licensee failed to protect its residents from financial abuse. The licensee did not administer the residents finances appropriately as evidenced by the issuing of checks made out directly to staff members on four separate occasions without prior approval from the Office of the Public Guardian and Trustee. This is not their regular practice as confirmed by the Administrator, the Manager and the Accounts Payable.

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

1. The licensee failed to notify the appropriate police force of the alleged financial abuse. The administrator became aware of this incident December 16, 2013 and after seeking clarification from her Senior Administrators did not notify the police. The police were contacted January 23, 2014. [S. 98.]

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Issued on this 18th day of March, 2014

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

A Spence Falkingham