Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
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130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2018	2017_566669_0032	022831-17, 022832-17	Follow up

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

ANDREA DIMENNA (669)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 20, 23, 24 and November 24, 2017.

This follow-up inspection was related to Compliance Orders #002 and #003 from the Resident Quality Inspection #2017_566669_0005, related to abuse.

The following complaint was completed concurrently with this inspection:

IL-53580-LO/Log #024184-17, related to abuse.

PLEASE NOTE: A Written Notification and Compliance Order under the Long-Term Care Homes Act, 2007, s. 24 identified in concurrent inspection #2017_566669_0029 (Log #024184-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care, Manager of Resident Services and Clinical Practice, Manager of Building Services, three Registered Nurses (RNs), two Registered Practical Nurses (RPNs), the Laundry Charge Person, two Healthcare Aides, three Personal Support Workers (PSWs), one Wash Person, and one Housekeeper.

During the course of the inspection, the Inspector made observations of residents, activities, interactions with staff, and provisions of care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2017_566669_0005	669

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	Legendé 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

This inspection was completed as a follow-up to Compliance Order #003 issued on July 25, 2017, during the Resident Quality Inspection (#2017_566669_0005) with a compliance due date of July 28, 2017. The order stated, "the licensee shall ensure that the home immediately reports the suspicion and the information upon which it is based to the Director when a person has reasonable grounds to suspect that abuse of a resident by anyone occurred."

A Complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, which alleged that an identified resident was abused by a staff member.

The home's policy, Zero Tolerance of Abuse and Neglect (#0104-08), dated September 18, 2017, was reviewed and stated that staff and management must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone. The policy also said that all incidents of nonconsensual sexual behaviour must be reported to the MOHLTC. The policy included that when abuse of a resident by anyone occurred, the action to be

taken by the home was to phone the after hours pager number (when outside of business hours) immediately upon becoming aware of the incident.

The home submitted a Critical Incident System (CIS) report to the MOHLTC approximately 14 hours after the resident’s allegation of abuse was made. The home did not call the MOHLTC after hours pager.

The identified resident's progress notes were reviewed and included documentation that the resident voiced allegations to an RN on a specified date and time. The RN charted that they had contacted the nurse leader on-call, the Manager of Resident Services and Clinical Practice (MRSCP), and updated them about the allegations. The note included that the MRSCP instructed the RN to send them an email of the RN's conversation with the resident, and that the MRSCP would follow up in the morning.

The home’s risk management system in PointClickCare was reviewed, and included an incident entered by the MRSCP related to alleged abuse of the identified resident. The incident note said that the MRSCP followed up with the resident approximately 12 hours after the resident's allegation of abuse was made.

A copy of the email sent by the RN to the MRSCP was reviewed. The email stated that the RN met with the resident at a specified date and time, and that the resident alleged they were abused by a staff member.

The RN was interviewed and recalled that the identified resident reported the allegation of abuse to them. The RN shared that they informed the resident that the home’s management, police, and the MOHLTC would be notified. The RN stated that once the resident was calmed and situated, they called the on-call manager, the MRSCP, to inform them of the resident’s allegation. The RN said that the MRSCP instructed the RN to email them, as the MRSCP wanted to first clarify the allegation by speaking with the resident.

The MRSCP was interviewed and stated that the home’s process when alleged or actual abuse was reported was to investigate, call the police, and report it to the MOHLTC immediately. The MRSCP recalled becoming aware of the allegation through a phone call they received on a specified date and time from the RN. The MRSCP explained that after they met with the identified resident approximately 12 hours later to discuss the allegation, the home submitted a CIS report.

The Administrator was interviewed and acknowledged that the home did not immediately report the identified resident's allegation of abuse, but should have.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level three as there was actual harm or risk, and the scope was isolated during the course of this inspection. This area of non-compliance was previously issued as: Compliance Order #003 during the Resident Quality Inspection (#2017_566669_0005) and had a compliance due date of July 28, 2017; a Written Notification during a Critical Incident System Inspection

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANDREA DIMENNA (669)
Inspection No. / No de l'inspection :	2017_566669_0032
Log No. / No de registre :	022831-17, 022832-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 5, 2018
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF ESSEX 360 Fairview Ave West, ESSEX, ON, N8M-1Y6
LTC Home / Foyer de SLD :	SUN PARLOR HOME FOR SENIOR CITIZENS 175 TALBOT STREET EAST, LEAMINGTON, ON, N8H-1L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynda Monik

To THE CORPORATION OF THE COUNTY OF ESSEX, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_566669_0005, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that the home immediately reports the suspicion and the information upon which it is based to the Director when a person has reasonable grounds to suspect that abuse of a resident by anyone has occurred.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

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The home submitted a Critical Incident System (CIS) report to the MOHLTC approximately 14 hours after the resident's allegation of abuse was made. The home did not call the MOHLTC after hours pager.

The identified resident's progress notes were reviewed and included documentation that the resident voiced allegations to an RN on a specified date and time. The RN charted that they had contacted the nurse leader on-call, the Manager of Resident Services and Clinical Practice (MRSCP), and updated them about the allegations. The note included that the MRSCP instructed the RN to send them an email of the RN's conversation with the resident, and that the MRSCP would follow up in the morning.

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The RN was interviewed and recalled that the identified resident reported the allegation of abuse to them. The RN shared that they informed the resident that the home's management, police, and the MOHLTC would be notified. The RN stated that once the resident was calmed and situated, they called the on-call

manager, the MRSCP, to inform them of the resident's allegation. The RN said that the MRSCP instructed the RN to email them, as the MRSCP wanted to first clarify the allegation by speaking with the resident.

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The severity of this issue was determined to be a level three as there was actual harm or risk, and the scope was isolated during the course of this inspection. This area of noncompliance was previously issued as: Compliance Order #003 during the Resident Quality Inspection (#2017_566669_0005) and had a compliance due date of July 28, 2017; a Written Notification during a Critical Incident System Inspection (#2014_257518_0048). (669)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Andrea DiMenna

Service Area Office / Bureau régional de services : London Service Area Office