Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2021	2021_890758_0020	017101-21	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Tullamore Care Community
133 Kennedy Road South Brampton ON L6W 3G3

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

DANIELA LUPU (758)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 23-24, 26, and 29-30, and December 1-3, and 6, 2021.

The following Critical Incident System (CIS) intake was completed during this inspection:

Log #017101-21, related to falls prevention and management.

PLEASE NOTE: This inspection was conducted concurrently with complaint inspection #2021_890758_0020.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Interim Director of Care (I-DOC)/Infection Prevention and Control (IPAC) Lead, Associates Director of Care (ADOC), Resident and Family Experience Coordinator (RFC), Director of Dietary Services (DDS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), screeners, housekeeping staff, and residents.

The inspector(s) observed staff to resident interactions, and infection prevention and control practices. They also reviewed clinical records, policies and procedures, staff schedules and relevant documents pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for falls prevention was provided to a resident as specified in the plan.

A resident's plan of care for falls prevention directed staff to implement specific interventions to minimize the risk of injuries from falls.

On three separate occasions the interventions were not implemented as specified in the resident's plan of care. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) said the falls prevention interventions should be followed as indicated in the resident's plan of care.

Not implementing the fall prevention interventions as specified in the resident's plan of care increased the resident's risk for injuries in case of a fall.

Sources: observations of resident's falls interventions, the resident's clinical records, and interviews with a PSW and an RPN. [s. 6. (7)]

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 to ensure that care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's falls prevention and management policy was complied with for a resident.

In accordance with O. Reg. 79/10, s.48 (1)1 and in reference to O. Reg. 79/10, s.49 (1), the licensee was required to have a fall prevention and management program that provided strategies to reduce or mitigate risks for falls, including monitoring of residents.

The home's Falls Prevention and Management policy documented that after a fall, staff should follow specific directions if there was suspicion or evidence of injury. The policy documented the physician should be contacted and/or arrange for immediate transfer of the resident to the hospital.

A resident was at risk for falls due to their medical condition. On a particular day, the resident had a fall and showed signs of a potential injury. The physician was not notified, and the resident was not transferred to the hospital until the next day when their condition deteriorated.

The home's I-DOC said the physician should have been notified and the resident transferred immediately to the hospital for further assessment.

By not following to directions when signs of potential injury were noted and not notifying the physician or immediately transferring the resident to the hospital as indicated in the home's falls policy, increased the risk that appropriate measures were not implemented to prevent complications associated with the resident’s injury.

Sources: resident's clinical records, the home's falls prevention and management policy, and interviews with the I-DOC, and other staff. [s. 8. (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 to ensure staff comply with the home's falls prevention and management policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program in relation to resident hand hygiene practices and appropriate usage of Personal Protective Equipment (PPE) for staff and visitors.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22, 2020, Directive #3 was issued and revised on July 16, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7 by the Chief Medical Officer of Health (CMOH) of Ontario. An urgent requirement was made for LTC Homes to implement measures to protect residents, staff and visitors, including adherence to hand hygiene practices and appropriate use of PPE.

A) The home's hand hygiene policy stated staff were to wash residents' hands before and after eating.

i) On four occasions, during the snack service, multiple residents were not assisted or encouraged with hand hygiene before eating their snacks.

ii) On two separate occasions during the lunch meal service, and on two occasions during the breakfast meal service, multiple residents were not offered or assisted with hand hygiene after eating.

The home's Interim DOC/IPAC Lead said residents should be offered and/or assisted with hand hygiene before and after eating their meals and snacks.

Sources: observations of breakfast and lunch meal service, the home's hand hygiene policy, Directive #3 (July 2021) and interviews with the I-DOC/IPAC Lead and other staff.

B) Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Hand Hygiene in All Health Care Settings, documented the preferred method for hand hygiene when hands were not visibly soiled was using an alcohol-based hand rub (ABHR) containing 70 to 90 per cent alcohol.

The home's hand hygiene policy, indicated that if hands were visibly soiled and running water was not available, moistened towelettes should be used to remove the visible soil, followed by the use of ABHR.

On one occasion, during the lunch meal service, multiple residents were offered or assisted with hand hygiene using alcohol-free wipes, after they finished eating.

The home's I-DOC/IPAC Lead and the Executive Director (ED) said alcohol-free wipes could be used for resident hand hygiene to remove visible soil from hands, followed by the use of ABHR containing at least 70 per cent alcohol.

Sources: observations lunch meal service, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Hand Hygiene in All Health Care Settings, 4th edition, April 2021, the home's hand hygiene policy, Directive #3 (July 2021) and interviews with the I-DOC/IPAC Lead and the ED.

C) The home's COVID-19 Prevention and Management policy, documented that staff and visitors should wear a surgical mask while indoors. The policy also documented that a health care worker should wear eye protection, mask, gown and gloves when collecting nasopharyngeal or oropharyngeal swabs.

i) On one occasion, a staff member was observed wearing their mask below their nose

while in close proximity of three residents during an activity in a resident home area.

ii) On a separate occasion, a visitor was observed wearing their mask below the nose while being in the screening area.

iii) On two occasions, two screeners did not wear eye protection when they collected nasal samples for rapid antigen testing from two individuals .

The home’s I-DOC/IPAC Lead said a surgical mask should be worn when indoors at all times and the mask should cover the mouth and nose. They also said full PPE including the eye protection should be used when collecting samples for rapid antigen tests.

D) At the time of this inspection, two residents were on droplet and contact precautions and their COVID-19 swabs were pending.

Public Health Ontario (PHO) Droplet and Contact precautions signage was posted on these residents' door. The signage directed staff to wear eye protection when they were within two meters of these residents.

On one occasion, a PSW entered these residents’ room and brought snacks to one of the residents. The PSW did not wear eye protection when they were less than two meters from this resident.

The home’s I-DOC/IPAC Lead said eye protection should be worn when within two meters of a resident placed on droplet contact precautions.

Sources: observation of PPE usage practices, the home's Droplet and Contact Precautions policy, the home's COVID-19 Prevention and Management policy, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, (November 2012); Directive #3 (2021), Public Health Ontario (PHO), Droplet and Contact Precautions signage, and interviews with the I-DOC/IPAC Lead and other staff. [s. 229. (4)]

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 to ensure that staff participate in the implementation of the home's Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 23rd day of December, 2021

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

Original report signed by the inspector.