



**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 prévue  
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**

Central West Service Area Office  
500 Weber Street North  
WATERLOO ON N2L 4E9  
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Facsimile: (519) 885-9454

Bureau régional de services du  
Centre-Ouest  
500 rue Weber Nord  
WATERLOO ON N2L 4E9  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-9454

## **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 11, 2019	2019_723606_0001	008625-18, 009808-18, 014735-18, 023710-18, 024813-18, 026758-18, 032145-18, 033430-18, 033612-18	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**

JANET GROUX (606), FARAH\_KHAN (695)

## **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 3, 4, 8, 9, 10, 11, 2019.**

**The following Critical Incident (CI) Systems were inspected:**

**Logs #009808-18, #023710-18, #032145-18, #033430-18 regarding the home's Falls Prevention and Management Program.**

**The following Follow Up orders were inspected:**

**Log #033612-18 #001 Regulation r. 15 (1) Bedrails and;**

**Log #024813-18 #002 Regulation 50. (2) (b) (iv) Skin and Wound Care.**

**PLEASE NOTE: Written Notification and Compliance Order related to O. Reg. 79/10, s. 8 (1) and Long Term Homes Act, 2007 s 6(10) and 6(11) were identified in this inspection and has been issued in a concurrent Complaint inspection report #2019\_723606\_0002.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Occupational Therapist (OT), Home Medical Equipment (HME) Accounts Manager, Personal Support Workers (PSW), Resident Relations Coordinator (RRC), Substitute Decision Makers (SDM), and residents.**

**During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.**

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

**Falls Prevention**

**Safe and Secure Home**

**Skin and Wound Care**



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

1 WN(s)  
0 VPC(s)  
0 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2018_723606_0014		606
O.Reg 79/10 s. 50. (2)	CO #002	2018_723606_0014		606



**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>Légende</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>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who require them on a short-term basis.

A CI reported resident #003 fell and sustained a serious injury.

The progress notes stated resident #003 was found on the floor in their room with injuries to identified areas of their body and was transferred to the hospital.

Resident #003's clinical records stated the resident has had a number of falls in the past due to the same cause and was referred to the Occupational Therapist (OT) to assess.

The OT stated that resident #003 was recommended for an identified type of mobility aide but was not initiated as the home was waiting for a response from the resident's SDM. They revealed that the home's identified service provider had a service to be able to lend an equipment for a resident who required it immediately but only on a short-term basis to use until they purchased their own equipment. They stated that the home did not initiate this service.

Account Manager #127 from the identified service provider stated that if a resident required equipment such as an identified mobility aide they would have been able to provide the mobility aide on a short term basis. They stated that they did not recall the home requesting an identified mobility aide for resident #003.

The licensee has failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who require them on a short-term basis. [s. 39.]



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**Issued on this 13th day of February, 2019**

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

**Original report signed by the inspector.**