Ontario

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

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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
Aug 7, 2019	2019_727695_0023	013307-19	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

FARAH_ KHAN (695)

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): July 31, August 1, 2, and 6, 2019.

During the course of the inspection, the following Critical Incident intake was inspected:
Intake #013307-19, related to an unexpected death.

During the course of the inspection the inspector toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures, and investigation records.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), housekeepers, maintenance worker, registered practical nurses (RPN), registered nurses (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

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

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

- **1 WN(s)**
- **1 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. 19. Duty to protect

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).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from neglect.

For the purpose of the Act and 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.

Critical Incident #0963-000045-19 was submitted stating that resident #002 passed away unexpectedly on a specific date in 2019 in the morning.

The resident's plan of care for transfers stated that they required assistance when weak or tired and the plan for toileting was that they required assistance from staff.

The home's investigation notes found that during the early morning before the resident passed away, they requested assistance from PSW #103 to help transfer them into the wheelchair. The PSW informed the resident that they could not assist due to their own health problems. There was no indication that the PSW requested another staff member to assist or provided an alternative for the resident. Shortly after, RPN #107 went to see the resident for having specific respiratory symptoms and administered a when-needed (PRN) medication for the symptoms. The resident's respirations and oxygen level were not assessed. In addition, their chest was not listened to with a stethescope. The RPN stated in the investigation notes that they asked the resident how they were feeling after the administration of the medication and that the resident stated they were better. The RPN saw the resident again an hour later when the resident requested for assistance to the toilet; according to the RPN, they informed the resident to go in their diaper as the PSWs were busy.

RPN #107 stated to the LTCH Inspector that if a resident is experiencing the specified respiratory symptoms they would check the oxygen levels and use their stethoscope to assess their chest. They would administer the PRN medication that was available and go back to reassess the resident's oxygen level and status. The RPN acknowledged that in the early morning before the resident passed away, resident #002 complained of the specific respiratory symptoms and that they did not check the resident's oxygen level, respiration rate or assess their chest that night.

The DOC acknowledged that the RPN and PSW failed to provide the care and assessments required for resident #002.

The licensee failed to ensure that resident #002 was protected from neglect. [s. 19. (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 that all residents are protected from neglect, to be implemented voluntarily.

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.