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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 01, 2021	2021_826606_0002 (A3) (Appeal\Dir#: DR# 144)	025128-20, 025929-20	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

Amended by Pamela Chou (Director) - (A3)(Appeal\Dir#: DR# 144)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#002.
The Director's review was completed on March 26, 2021.
Order(s) CO#002 was/were rescinded to reflect the Director's review DR# 144.

Issued on this 1 st day of April, 2021 (A3)(Appeal\Dir#: DR# 144)

[redacted]

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

Original report signed by the inspector.

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
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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
Apr 01, 2021	2021_826606_0002 (A3) (Appeal/Dir# DR# 144)	025128-20, 025929-20	Critical Incident System

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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

Amended by Pamela Chou (Director) - (A3)(Appeal/Dir# DR# 144)

Amended 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): January 8, 11, and 14, 2021.

The following intakes were inspected:

Log #025128-20 regarding the breakdown of one of the Home's main heating system and Log #025929-20 regarding a respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Director of Environmental Services (DES), Corporate Building Services Consultant, Registered Nurses (RN), Personal Support Workers (PSWs), Housekeeping and Maintenance Staff.

During the course of the inspection the inspector observed staff and resident interactions, provision of care, reviewed residents' health records, and other relevant documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Infection Prevention and Control

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the home's main heating system was maintained in a safe condition and in a good state of repair.

A CI reported failure of the Home's main heating system which caused a decrease in the air temperatures in two of the Home's units.

In April 2020, the Home's main heating system, was deemed a Category A-Immediate Hazard and was unsafe to use in its current condition. The Home was not able to provide information about what action the Home took to address the issue identified.

In December 2020, the Home's main heating system lost function and caused the air temperatures to decrease below 22 degrees celcius in two of the Home's units. The Home had to put several interventions in place to ensure residents were kept warm. It was also reported that air temperatures reached a temperature level that set off the the Home's sprinkler system and fire alarm. This caused water from the sprinklers to enter some of the residents' rooms; and a number of residents had to be moved from their rooms into the hallway.

The DES said the Home's main boiler system was an old heating system installed over 40 years ago and was not in a good state of repair.

Sources: CI report, observations, and Interviews with staff. [s. 15. (2) (c)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that a safe and secure environment was provided for its residents specifically related to the home's implementation of their infection prevention and control program.

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 and 30, 2020, Directive #3 was issued and revised on December 7, 2020, 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. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

The Home was declared in a COVID-19 outbreak by Peel Region Public Health after a staff member tested positive for COVID-19. On the third day of the outbreak, one resident tested positive for COVID-19. On the tenth day of the

outbreak, the Home identified 18 residents who resided on the same unit positive for COVID-19, along with four more staff members.

Observations during the inspection identified the following:

-A PSW was observed in the room of a COVID-19 positive resident. Prior to exiting the room, the PSW removed some of their Personal Protective Equipment (PPE) but did not remove their mask and put on a new one.

- A resident, who did not have COVID-19 shared a room with a symptomatic COVID positive resident. There was very little separation between the residents beds and their curtains were not closed to create separation.

-Resident cohorting had not been fully established. COVID-19 positive residents were observed to share rooms with those that were negative and distancing of two metres was not maintained

-During a shift change, the floor markers for social distancing were not followed and staff were observed in close contact with staff who were wearing contaminated PPE.

-During the same shift change, a number of staff exited the unit dedicated for COVID-19 positive residents without disinfecting their face shields, and putting on a new mask.

On Day 13 of the outbreak, there was evidence of further transmission of COVID-19 with cases identified on another unit. An increase in both positive residents and staff was reported.

The Licensee did not fully implement the IPAC and PPE measures outlined in the CMOH Directives. which may have contributed to the the transmission of COVID-19 within the home.

Sources: CI report, Region of Peel COVID-19 Outbreak Line Listing (Resident/Patient Cases), Peel COVID-19 Outbreak Line Listing (Staff Cases), and interviews with the DOC, ADOC, registered staff, and PSWs. [s. 5.]

Additional Required Actions:

(A3)(Appeal/Dir# DR# 144)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 002

Issued on this 1 st day of April, 2021 (A3)(Appeal/Dir# DR# 144)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Pamela Chou (Director) - (A3) (Appeal/Dir# DR# 144)
Inspection No. / No de l'inspection :	2021_826606_0002 (A3)(Appeal/Dir# DR# 144)
Appeal/Dir# / Appel/Dir#:	DR# 144 (A3)
Log No. / No de registre :	025128-20, 025929-20 (A3)(Appeal/Dir# DR# 144)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 01, 2021(A3)(Appeal/Dir# DR# 144)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Tullamore Care Community 133 Kennedy Road South, Brampton, ON, L6W-3G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Katie Hutchins

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The Licensee must comply with s. 15 (2) (c) of O. Reg. 79/10.

Specifically, the Licensee must ensure that:
1. the Home's main hot water heating system is maintained in a safe condition and in a good state of repair.

2. Action items to address all recommendations that result from inspections of the home's heating and boiler systems are documented including the person responsible and the timelines for completion. A record of this must be kept in the home and accessible at anytime for review.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that the home's main heating system was maintained in a safe condition and in a good state of repair.

A CI reported failure of the Home's main heating system which caused a decrease in the air temperatures in two of their resident home areas (RHA).

During an observation of the Home's main heating system, a red tag warning for Category A-Immediate Hazard was attached to the equipment and was deemed

unsafe to use in its current condition. The Home was not able to provide information about what the Home did to address the issue identified.

.

In December 2020, the Home's main heating system lost function and caused the air temperatures to decrease below 22 degrees celcius in two of the Home's RHAs. It was reported that the air temperature in one of the RHA affected, reached a temperature level that set off the the Home's sprinkler system and fire alarm. This caused water from the sprinklers to enter some of the residents' rooms. A number of residents were moved from their rooms into the hallway. Residents who complained about being cold were provided blankets and heaters.

The DES said the Home's main boiler system was an old heating system installed over 40 years ago and was not in a good state of repair.

Sources: CI report, observations, and Interviews with staff. [s. 15. (2) (c)]

An order was made by taking the following factors into account:

Severity: There was a risk of harm when the licensee failed to ensure the Home's main hot water heating system was maintained in a safe condition and in a good state of repair. There was actual risk and potential for harm because residents were exposed to the cold air temperatures which could have triggered further changes to their health conditions.

Scope: This non-compliance was widespread as the boiler system heats the whole home and had the potential to impact all residents.

Compliance History: There was a previous NC to a different subsection in the past 36 months.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 26, 2021(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

(A3)(Appeal/Dir# DR# 144)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

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

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

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 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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 1 st day of April, 2021 (A3)(Appeal/Dir# DR# 144)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Pamela Chou (Director) - (A3) (Appeal/Dir# DR# 144)

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

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

Service Area Office / Bureau régional de services : Central West Service Area Office