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_0019	016975-21	Complaint

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 Complaint inspection.

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

The following complaint intake was completed during this inspection:

Log #016975-21, related to concerns regarding operations of the home and resident care and services.

PLEASE NOTE: This inspection was conducted concurrently with critical incident system inspection #2021_890758_0019.

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), Director of Resident Programs, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a dietary aide, and residents.

The inspector(s) observed staff to resident interactions, and meal and snack services. They also reviewed clinical records, policies and procedures, and relevant documents pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Reporting and Complaints
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 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. (12) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents were given an explanation of their plan of care regarding the COVID-19 vaccine.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding the lack of information about the COVID-19 vaccines provided to the residents.

On December 16, 2020, vaccine educational documents were shared by the MLTC with the long-term care homes related to the Pfizer-BioNTech COVID-19 vaccine. On January 1, 2021, informational material was shared regarding the Moderna vaccine and its administration. On January 14, 2021, a letter from the Chief Medical Officer of Health (CMOH) and the MLTC along with a fact sheet regarding COVID-19 vaccines were shared with all long term-care homes. The homes were advised to provide education to all vaccines recipients about the development of vaccines, clinical trials, and safety protocols.

i) A resident declined their consent to the COVID-19 vaccine. The resident stated they were not provided with any informational material related to COVID-19 vaccines necessary to make an informed decision.

ii) Two different residents received their COVID-19 vaccine on specific dates. The residents said no information about the COVID-19 vaccines was provided prior to their vaccine administration.

The home's I-DOC/IPAC Lead said there were no records that the information about the COVID-19 vaccines was provided to the residents before the second dose was administered.

By not providing an explanation regarding the COVID-19 vaccine increased the risk that the residents were unable to make an informed decision about their vaccination.

Sources: the residents' clinical records, the home's COVID-19 resident immunization Program, Vaccines educational documents (December 16, 2021), Deputy Minister memorandum (January 1 and 5, 2021), Letter from CMOH and MLTC -COVID-19 vaccine for Ontario (January 14, 2021) and interviews with residents and the home's I-DOC/IPAC Lead. [s. 6. (12)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that five written complaints concerning resident care and services and the operations of the home were immediately forwarded to the Director.

On three separate occasions, three written complaints were received by the home's Resident and Family Experience Coordinator (RFC) regarding operations of the home and a resident's care and services. On two different occasions, two additional written complaints were received by the home regarding the same resident's care and services. None of these complaints were forwarded to the Director.

The home's ED said that any written communication including emails concerning the care of a resident or operations of the home should be immediately forwarded to the Director.

Sources: the home's complaint records, the home's complaint management program, a resident's email correspondence and an interview with the home's ED. [s. 22. (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 any written complaint concerning the care of a resident or the operation of the long-term care home is immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided within 10 days of receiving concerns and recommendations from the Resident's Council regarding the operations of the home.

A complaint was received by the MLTC regarding lack of response to concerns expressed by the Resident's Council.

The Resident's Council minutes from a specified period of time, documented multiple concerns related to operations of the home. There were no records of written responses to these concerns.

The home's ED confirmed that no written responses were provided to the Resident's Council for the specified time.

Sources: the home's Resident's Council meeting minutes, interviews with the home's ED and residents. [s. 57. (2)]

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 when the Residents' Council has advised of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee responded within 10 days of receiving the advice, to the Residents' Council in writing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the interventions to mitigate and manage the risks related to nutrition care and dietary services were implemented for two residents.

A complaint was received by the MLTC related to dietary and food services.

i) A resident was at nutritional risk and their care plan directed staff to serve the planned menu items as ordered by the resident to mitigate risks associated with receiving incorrect food items or not at the appropriate temperature.

In a five-month period, on two occasions, the resident received food items at the incorrect temperature and on six occasions they received incorrect or incomplete menu items which resulted in them getting upset and refusing meals.

A Registered Practical Nurse (RPN) said the resident would refuse meals when food or beverages were not received as the resident requested or if they were not at the appropriate temperature.

The home’s Director of Dietary Services (DDS) acknowledged that on several occasions the resident was served incorrect food items or not at the appropriate temperature due to either errors in receiving or in processing the resident's food orders. They also said the delays in serving the food to the resident resulted in receiving the food and/or beverages at an inappropriate temperature.

Not ensuring that interventions to mitigate and manage the risks related nutrition care and dietary services for the resident were implemented increased the risk of negative outcomes associated with the resident not eating their meals.

Sources: the resident’s clinical records, the home’s outbreak meal tray audits, interviews with the resident, DDS and other staff.

ii) A resident was at moderate nutritional risk and had a specific diet texture for food and fluids. The resident’s care plan documented potential for negative outcomes when care was not provided as planned.

On two occasions, the resident's meal was not served as ordered and on one occasion they received the incorrect texture for their dessert which resulted in them being upset.

The home's DDS acknowledged the gaps in serving the menu items as ordered by the resident.

Not implementing interventions to mitigate risk related to nutrition care and dietary services put the resident at risk for negative outcomes associated with receiving

incomplete or incorrect food items.

Sources: observation of lunch meal service, the resident's clinical records, the resident's lunch meal tray ticket, interviews with the resident, the home's DDS and other staff. [s. 68. (2) (c)]

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 interventions to mitigate and manage risks related to nutrition care and dietary services and hydration are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served course by course to the residents.

On one occasion, during the lunch meal service, the main entree and the dessert were served at the same time and before multiple residents finished their first course.

On three occasions, the residents had their main entree served at the same time as their dessert.

The home 's DDS said that meals should be served course by course, but the process was not fully implemented.

Not serving meals course by course increased the risk that food were not served at the appropriate temperature and residents would not have a pleasurable dining experience.

Sources: observations of the meal services, the home's outbreak tray service at dinner for a resident, and interviews with residents, the home's DDS, and other staff. [s. 73. (1) 8.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents and meals are served course by course for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record of complaints was kept in the home and included the date of the action taken to solve the complaint, time frames for the action to be taken, any follow up action required including every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

A complaint was received by the MLTC regarding incomplete follow up and lack of response to a resident's verbal and written complaints.

i) One one occasion, a verbal complaint was made by a resident to a staff member related to the operations of the home. There was no record of this complaint kept in the home.

ii) On three occasions, three written complaints were received by the home's RFC and on one separate occasion a verbal complaint was received by a staff member regarding resident care and services and operations of the home. The complaint forms were incomplete.

The home's ED acknowledged that the complaint records were incomplete for the above complaints.

Sources: the home's complaint records, the home's complaint management program, the resident's progress notes and email correspondence, and interviews with the home's I-DOC, and ED. [s. 101. (2)]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint and a documented record is kept in the home that includes (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, 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.