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

Central West Service Area Office
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Original Public Report

Report Issue Date July 29, 2022
Inspection Number 2022_1015_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long-Term Care Home and City
Tullamore Care Community, Brampton

Lead Inspector
Romela Villaspir (653)

Inspector Digital Signature
Romela Villaspir
2022.08.03
14:34:07 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 11-15, 18-19, 21-22, 25, 2022.

The following intakes were inspected during this inspection:
Log #019572-21 was a complaint related to an allegation of resident neglect.
Log #001096-22 and Log #005885-22 were related to staff to resident abuse.
Log #010967-22 was related to an unexpected death of a resident.
Log #012830-22 was related to an injury from unknown cause.
Log #018671-21, Log #004515-22, and Log # 010625-22 were related to falls prevention and management.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: Point-of-care signage indicating that enhanced IPAC control measures are in place and additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal.

The home's Additional Precautions (AP) policy indicated that the elements that comprised AP included specialized accommodation and signage specific to the type of AP. AP must be initiated as soon as symptoms suggestive of a transmissible infection were noted for residents known to have or considered to be at high risk of being colonized or infected with antibiotic-resistant organisms (AROs). Initiation of AP should not wait until laboratory confirmation of status.

Public Health (PH) declared the home on suspect respiratory outbreak.

A) The IPAC Lead stated that once a resident presented with signs and symptoms of respiratory infection, they would be put on isolation, and get tested.

The inspector noted that additional precautions signage and a PPE caddy were not put in place right away for a resident who was tested.

B) During two separate observations, a PPE caddy was outside of a resident's room, however, there was no additional precautions signage posted on their door as required.

There was moderate risk at the time of non-compliance, as the home was on suspect respiratory outbreak, and later on was declared on a confirmed respiratory outbreak.

Sources: Inspector #653's observations; Additional Precautions policy #: IX-G-10.70 revised December 2021, residents' clinical health records; Interviews with the IPAC Lead, and the Director of Care (DOC). [653]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 53 (4) (b)

The licensee has failed to ensure that strategies were implemented to respond to a resident's responsive behaviours.

Rationale and Summary

A resident was at risk for falls due to different factors including responsive behaviours. The resident's care plan identified approaches and support actions to address their responsive behaviours and to prevent them from falling.

On one occasion, the resident attempted to get up from their personal assistive device multiple times. A Registered Practical Nurse (RPN) used physical force on the resident to prevent them from getting up and walking away from their personal assistive device. The RPN also attempted to transport the resident using physical force while the resident was resistive.

By not implementing the strategies to respond to the resident's responsive behaviours, the resident became more physically responsive, and their safety was put at risk by the RPN during their entire interaction.

Sources: Resident's clinical health records, Critical Incident System (CIS) report, the home's investigation notes; Interviews with a Personal Support Worker (PSW), Behavioural Support Ontario (BSO) RPN, Assistant Director of Care (ADOC), and the DOC. [653]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 3 (1) 11 (iv)

The licensee has failed to fully respect and promote a resident's right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

Rationale and Summary

On one occasion, a resident attempted to get up from their personal assistive device multiple times. A RPN used physical force on the resident to prevent them from getting

up and walking away from their personal assistive device. The resident became physically responsive towards the RPN.

Following the RPN's interaction with the resident, the RPN did not keep the resident's information confidential when they had spoken to a co-resident's Substitute Decision-Maker (SDM) about the resident. Furthermore, the RPN and BSO RPN had a conversation about the resident inside a co-resident's room, and in the hallway when they were six feet apart.

Sources: Resident's clinical health records, CIS report, the home's investigation notes; Interviews with a PSW, BSO RPN, ADOC, and the DOC. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A resident developed a medical condition towards the end of their life, as evidenced by three separate lab results taken within a span of seven months.

Two full-time RPNs, and two full-time Registered Nurses (RNs) were not aware that the resident had developed a medical condition.

Upon review of the lab results with the Attending Physician (AP), the AP stated that the first two lab results did not warrant aggressive therapy. This would have been addressed with conservative therapy such as a lifestyle change through dietary interventions. The AP also indicated that these should have been addressed with the whole team effort, and it was not. The AP further indicated they were not sure what happened as to why the third lab result that was outside of normal limits was missed. The AP stated it should have been addressed.

The Registered Dietitian (RD) was not aware of the lab results, and they did not receive any referral to address this. The RD further indicated had they been made aware, they would have spoken to the resident and their family, and come up with interventions for management.

The lack of collaboration between the nursing staff, RD, and the AP, in developing and implementing the resident's plan of care, resulted in an untreated medical condition for an unknown period of time.

Sources: Resident's clinical health records, hospital notes, CIS report; Interviews with the AP, RPNs, RNs, the RD, and DOC. [653]