Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report (A1)

Report Issue Date: February 17, 2023	
Inspection Number: 2022-1015-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Tullamore Care Community, Brampton	
Inspector who Amended Romela Villaspir (653)	**Inspector who Amended Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.02.17 13:27:36 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the new Compliance Due Date (CDD) of March 13, 2023, as per the home's request for CDD extension. The Complaint and CIS inspection #2022-1015-0002 was completed on November 7-9, 14-18, and 21-24, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

November 7-9, 14-18, and 21-24, 2022.

The following intake(s) were inspected:

- Log #00001857, related to resident neglect
- Log #00008757, related to resident abuse
- Log #00005875, complaint related to improper care
- Log #00006304, complaint related to resident abuse and neglect
- Log #00013311, complaint related to resident's rights.

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

Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect

Food, Nutrition and Hydration
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the personal protective equipment (PPE) requirements set out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units effective October 6, 2022, was complied with.

Rationale and Summary

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022) requires the licensee to ensure that all staff interacting within two meters of a resident with suspect or confirmed COVID-19 wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent) as appropriate PPE.

At the time of this inspection, one resident was placed on enhanced droplet and contact precautions.

Signage posted at the entrance of the resident's room directed staff to wear PPE including eye protection and an N95 mask.

On two separate occasions, four Personal Support Workers (PSW) did not wear the required PPE when they were providing care to the resident.

The Director of Care (DOC)/Interim IPAC Lead said staff should have worn the required PPE as indicated on the enhanced droplet and contact precautions signage.

Sources: observations of a resident's care, a resident's progress notes, the home's policy related to N95

Respirator Team Members and Students, Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022), and interviews with a PSW and the DOC/Interim -IPAC Lead. [758]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 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 O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 indicates that Routine Practices should be followed in the IPAC program and should include proper use of Personal Protective Equipment (PPE), such as appropriate selection, application, removal, and disposal.

The home's PPE policy, indicated that all team members should use professional judgment and guidelines in making a decision about the type of PPE to be used depending on the potential for direct contact with body fluid.

Routine Practices and Additional Precautions in All Health Care Settings, Provincial Infectious Diseases Advisory Committee (PIDAC), third edition, last revised in November 2012, documented that if the face was exposed to a splash, spray, cough or sneeze, facial protection should be worn.

On one occasion, a staff member did not wear eye protection when they collected a nasal swab from a staff member.

A different staff member said they were not aware of any specific directions regarding the PPE required when collecting nasal swabs for Rapid Antigen Test (RAT).

The DOC/Interim IPAC Lead said staff should wear eye protection in addition to a mask when they were collecting nasal swabs for RAT.

By staff not wearing the appropriate PPE there was a potential risk of exposure and for spreading infectious microorganisms amongst residents, staff, and visitors.

Sources: observation of testing practices, the home's PPE policy, IPAC Standard (April 2022), Routine Practices and Additional Precautions in All Health Care Settings, PIDAC, (November 2012), and interviews with a staff member, and DOC/Interim IPAC Lead. [758]

WRITTEN NOTIFICATION: Reports of Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of two respiratory outbreaks.

Rationale and Summary

A respiratory outbreak was declared at the home by the Public Health Unit (PHU). The outbreak was not reported to the Director until six days later.

A second respiratory outbreak was declared at the home by PHU, but the outbreak was not reported to the Director until one day later.

By not immediately reporting the two respiratory outbreaks to the Director, the Director was unable to respond to the incidents in a timely manner.

Sources: two critical incident (CI) reports, and interviews with DOC/Interim IPAC Lead and Associate Director of Care (ADOC)/Interim IPAC Lead. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that the interventions provided to a resident and the resident's responses to interventions were documented.

Rationale and Summary

On one occasion, a resident was observed being upset while going towards the nursing station.

The resident informed a Registered Nurse (RN) that their oxygen was not infusing properly. The RN checked and resolved the issue before the resident left the home.

The RN said they did not document the interventions they provided and the resident's response.

By not documenting the interventions provided to the resident, other team members were not made aware of the concern and would not be able to take appropriate actions if any adverse events occurred.

Sources: a resident's progress notes, and interviews with an RPN, RN and the DOC. [758]

WRITTEN NOTIFICATION: Food Production

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (e)

The licensee has failed to ensure that a menu substitution of similar nutritional value was provided for a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the food production procedure for menu substitutions is complied with.

The home's Menu Substitutions policy documented that the Director of the Dietary Services (DDS) would make menu changes of similar nutritional value that reflected the preferences of the resident. The cook and/or the Dietary Team would obtain approval for substitutions from the DDS before implementing the change. In the absence of the DDS, the cook or the Dietary Team were to make the substitution and record it on the substitution form.

A resident was at nutritional risk and had an individualized pre-selected menu. On one occasion, the resident received a menu substitution item with a different nutritional value than their original individualized menu and they were not informed about the substitution. The resident was upset and refused to eat their meal.

The home's DDS said the substitution did not have a similar nutritional value. They also said the cook did not follow the home's procedure for making menu changes; the cook did not communicate with the resident and staff and did not inform the DDS as required.

By not providing menu substitutions that had similar nutritional value there was a risk that the resident did not meet their nutritional requirements as indicated in their individualized plan of care.

Sources: a resident's care plan, progress notes and pre-selected menu, the home's Menu Substitutions policy, and interviews with a PSW, the DDS and other staff. [758]

WRITTEN NOTIFICATION: Complaints Procedure

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)

The licensee has failed to ensure that written procedures for managing a resident's verbal complaints were complied with.

Rationale and Summary

A resident was at nutritional risk and had multiple complaints related to food quality and service.

The resident's food-related concerns included receiving a food item with a different nutritional value than they ordered, a food item was not available, and a different food item was not received as ordered and food not cooked properly.

The Executive Director (ED) said that for any complaints received from residents or staff a complaint form should be filled out and the complaint directed to the departmental manager.

The DDS said they were not informed of the above concerns expressed by the resident and did not receive a complaint form for any of these concerns. As a result, they could not take appropriate actions to resolve the concerns and prevent recurrence.

Staff not following the home's complaints process increased the risk that complaints would not be followed up in a timely manner and appropriate actions taken to prevent recurrence.

Sources: a resident's progress notes, the home's Complaints Management Program, and interviews with a resident, DDS, ED, and other staff. [758]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The home failed to ensure their Prevention of Abuse and Neglect policy, was complied with.

Rationale and Summary

Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The home's Prevention of Abuse and Neglect of a Resident policy documented that support and/or counselling would be offered to all victims of alleged abuse/neglect. The nurse would check the resident's condition to assess their safety and emotional and physical wellbeing. The resident would be offered emotional support and provided with a list of internal resources, including the social worker, pastoral care and external local resources as available. Staff were directed to document the current resident's status on the resident's health record and complete the required documentation for the provincial health authority. The resident's plan of care would be updated and staff would be ensured that the direct care team members were aware of the resident's current status.

A Critical Incident (CI) submitted by the home reported a resident was abusive towards three residents.

One of these residents said they were upset and angry as a result of the interaction with the abusive resident.

The resident's clinical records in Point Click Care (PCC) did not identify that a follow up was completed for the resident as outlined by the home's Prevention of Abuse and Neglect of a Resident policy.

The resident said they were not offered emotional support and they were not provided with any internal resources after the incident.

Sources: a critical incident, the home's Prevention of Abuse and Neglect, policy, three residents' clinical records, and interviews with residents and staff. [606]

WRITTEN NOTIFICATION: Duty to Protect

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee failed to ensure that a resident was protected from emotional abuse.

Rationale and Summary

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including

imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident liked socializing with their friends while consuming a recreational substance .

After an incident where the resident and another resident were observed consuming the recreational substance in a non-designated area, the resident was not allowed to use the recreational substance. Two days later, when the resident was observed consuming the recreational substance in the designated area, the home advised the resident they were no longer allowed to go to the designated area to socialize with other residents.

On multiple occasions, in a five-month period, the resident was accused and reminded of the incident. At one point, when the resident was observed using a recreational substance in the designated area, staff asked them to stop consuming the recreational substance, hand it to staff, and they were escorted inside the building. The resident was tearful and upset as they felt they were being treated unfairly.

The resident said they felt they were being treated like a baby as staff were constantly telling them what to do in relation to the use of the recreational substance. They felt targeted and blamed for the incident each time they requested or tried to go out to consume the recreational substance.

As a result of staff repeatedly telling the resident that they could not use the recreational substance because they caused the incident, nor could they go out and socialize with their friends at the designated area, the resident felt isolated and sad.

Sources: a critical incident, a resident's progress notes, the home's investigative notes, interviews with a resident, ED, DOC, ADOC, RFC, and other staff. [758]

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 3 (1) 2.

The licensee shall:

1) Review and revise the current specific recreational substances assessment to ensure that it includes clear criteria that determines whether a resident is safe to consume the recreational substance in the designated area.

2) Ensure that the specific assessment criteria are applied consistently for all residents.

3) Ensure that once the guidelines for the use of the specific recreational substance and the assessment are updated, the resident is reassessed in relation to the recreational substance use.

Grounds

The licensee failed to ensure that a resident's right to have their lifestyle and choices respected in relation to the use of a recreational substance, was fully respected.

Rationale and Summary

A resident enjoyed socializing with their friends while consuming a specific recreational substance. The resident was assessed at their admission as being safe to use the recreational substance, and subsequently on each assessment quarterly and annually until approximately one month before an incident occurred at the home.

After an incident occurred at the home, the resident agreed to a program to stop using the recreational substance.

The resident's assessment for the use of the recreational substance after the incident, documented that the resident was unsafe to use it although the previous assessment did not identify any safety concerns. There was no documentation or assessments to support the resident's physical or cognitive inability to safely use the recreational substance. Four different residents' assessments for the use of the same recreational substance documented similar concerns, but the residents continued to be allowed to consume it in the designated area.

Three days after the incident, the resident was observed consuming the recreational substance and was no longer allowed to use it and/or go to the designated area with the other residents.

During multiple occasions, the resident expressed their desire to consume the recreational substance and to be with their friends in the designated area.

The home's Recreational substances policy, documented that a risk assessment with the interprofessional team was required to be completed to determine how recreational substances were provided, purchased and delivered. The assessment was to include resident's diagnosis, history and

pattern of recreational substance abuse, ability to store the recreational substance safely, and ability to safely consume the recreational substance without increasing the risk to self or others.

The home's Guidelines for a specific recreational substance use documented if a resident was an active user an assessment was to be completed on move in, quarterly, annually, and with any change in resident's status.

One of the home's ADOC said that the recreational substance assessment did not provide specific direction to determine the safety risk for use. They stated that the registered staff were to determine if a resident was unsafe to use the specific recreational substance based on the answers completed in the assessment and their clinical judgment.

No attempts were made to collaborate with the resident to identify an individualized plan despite the resident's expressed wishes to use the recreational substance on multiple occasions.

By not respecting the resident's lifestyle choices related to the use of recreational substance resulted in emotional upset and social isolation of the resident.

Sources: four residents' clinical records, the home's recreational substances and guidelines for smoking policies, the home's investigative notes, and interviews with a resident, ED, DOC, ADOC, RFC, and other staff. [758]

This order must be complied with by March 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.