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

Original Public Report

Report Issue Date: April 28, 2023

Inspection Number: 2023-1015-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

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

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

Lead Inspector	**Inspector Digital Signature**
Amanpreet Kaur Malhi (741128)	Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2023.04.28 15:07:10 -04'00'

Additional Inspector(s)
Jessica Bertrand (722374)

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 4-6, 11-14, and 18, 2023

The following intake(s) were completed:
- Intake #00016271, related to Follow-up #1, FLTCA, 2021, s. 3 (1) 2.
- Intake #00020044, related to abuse
- Intake #00022638 and intake #00017833, related to falls
- Intake #00020758, complaint related to improper care
- Intake #00086043, complaint related to food quality

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1015-0002 related to FLTCA, 2021, s. 3 (1) 2. inspected by Amanpreet Kaur Malhi (741128)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)

A) The licensee has failed to comply with the process of taking immediate actions when they became aware of allegations of abuse towards a resident.

In accordance with O. Reg. 246/22, s. 11(1)(b), the licensee is required to ensure the policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support resident who have been allegedly abused and is complied with.

Rationale and Summary:
The home's Prevention of Abuse & Neglect of a Resident Policy, #VII-G-10.00, last revised October 2022, indicated that if any team member suspected an incident of abuse of a resident by anyone, the nurse would check the resident's condition to assess their safety and emotional and physical wellbeing and would contact the Executive Director or designate (if not in the community) when it was confirmed the resident was safe and had received appropriate care.

Staff reported that resident #008 inappropriately touched resident #002. No assessments were completed for resident #002 and they did not inform the nurse immediately.

By failing to follow the home's procedures when allegations of abuse were brought forward, there was a

risk that resident #002 would not have received support needed based on the assessments.

Sources: progress notes and assessments for resident #002 and #008, home's investigation notes, interviews with RPN #115, ADOC #118, Prevention of Abuse & Neglect of a Resident Policy, #VII-G-10.00, last revised October 2022.

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B) The licensee has failed to comply with the process of investigating alleged abuse after they became aware of an incident involving involving resident #008 towards resident #002.

In accordance with O. Reg. 246/22, s.11(1)(b), the licensee is required to ensure the policy to promote zero tolerance of abuse and neglect of residents identifies the manner in which allegations of abuse and neglect will be investigated and is complied with.

Rationale and Summary
The home's Prevention of Abuse & Neglect of a Resident Policy, #VII-G-10.00, last revised October 2022, indicated that the Executive Director or designate would initiate the investigation for alleged abuse. In this process, they would request that anyone aware of or involved in the situation would write, sign and date a statement accurately describing the event and the written statements would be obtained as close to the time of the event as possible.

The home's management did not complete interviews with staff within ten days of becoming aware of the alleged abuse from resident #008 towards resident #002.

By failing to obtain written statements as close to the time of event as possible, there was a risk that the written statement would not accurately reflect the incident.

Sources: resident #002 and #008 progress notes, risk management #2246 dated February 4, 2023, home's investigation notes, interview with ADOC #118, Prevention of Abuse & Neglect of a Resident Policy, #VII-G-10.00, last revised October 2022.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154(3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary
As per the CI submitted to the Director, staff did not immediately report to the management the alleged abuse incident of resident #002.

By failing to report the allegation of abuse immediately, the Director was unable to respond to the incident in a timely manner.

Sources: After hours report #IL-09922-AH, the home's investigation notes, interview with RPN #115 and ADOC #118.

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