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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: June 8, 2023	
Inspection Number: 2023-1015-0004	
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	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.06.08 14:52:41 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 29-31, and June 1-2, 5-6, 2023.

The following intake was inspected in this Complaint inspection:
- Intake #00085583 was related to resident charges, medication, plan of care, nutrition and hydration, and Infection Prevention and Control (IPAC) concerns.

The following intakes were inspected in this Critical Incident (CI) inspection:
- Intakes #00022071 and #00084083 were related to abuse.

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #001 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

An incident occurred between two residents, and an injury to one of the residents was later identified by a Registered Practical Nurse (RPN).

The on-call manager and the Executive Director (ED) were not made aware of the injury that was noted by the RPN a few hours after the incident. In addition, the incident was not reported to the Ministry of Long-Term Care (MLTC).

The on-call manager acknowledged that if the resident's injury resulted from the incident that occurred, then it should have been reported to the MLTC.

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

Sources: Residents' clinical health records; Interviews with a RPN, Resident & Family Experiences Coordinator, the ED, and other staff. [653]