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:** January 18, 2024

**Inspection Number:** 2023-1015-0006

**Inspection Type:**
Complaint
Critical Incident

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

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

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Romela Villaspir (653) | Romela Villaspir<br>Digitally signed by Romela Villaspir<br>Date: 2024.01.18 13:27:12 -05'00' |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 3-5, 8-10, 2024.

The following intakes were completed during this Complaint inspection:

- Intake: #00100099 related to an allegation of neglect, skin and wound care, and continence care and bowel management.
- Intake: #00100351 related to the home's infection prevention and control program.

The following Critical Incident (CI) intake was inspected:

- Intake: #00099233 related to a respiratory outbreak.

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (2)**
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that any actions taken with respect to a resident under the skin and wound care program, including interventions and the resident's responses to interventions were documented.

**Rationale and Summary**

A resident sustained an altered skin integrity.

The Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs) implemented an intervention for this altered skin integrity.

The Director of Care (DOC) acknowledged this intervention was not documented in the resident's plan of care, and it should have been.

**Sources:** Resident's clinical health records; Interviews with the DOC, and other staff. [653]

## WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident exhibiting altered skin integrity, including a Pressure Injury (PI), received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

**Rationale and Summary**

The Ministry of Long-Term Care (MLTC) received a complaint regarding the inconsistent application of a wound dressing on a resident.

A resident sustained a PI.

Subsequent weekly wound assessments showed worsening of the PI.

The resident's electronic Treatment Administration Record (eTAR) for a period of three months did not show any wound treatment for their PI.

The DOC stated that there should have been a wound treatment order in place on the eTAR. The DOC further stated that there was a directive on Point Click Care (PCC) for wounds, and acknowledged this was not implemented by the nurses.

The registered staff indicated that at one point, they applied a dressing on the resident's PI, but could not recall the time period. There were no progress notes indicating the application of a dressing, and that the dressing was changed regularly.

By not initiating the appropriate wound treatment on the eTAR, the resident's PI continued to worsen, as the resident did not receive immediate and consistent treatment to reduce or relieve pain, promote healing, and prevent infection, as required.

**Sources:** Resident's clinical health records, the home's Wound Management Algorithm; Interviews with the DOC, and the RPNs. [653]

## COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

1) Re-educate and test the knowledge of all Personal Support Workers (PSWs), a RPN, and a Maintenance Team Member on the four moments of hand hygiene.

2) Provide face to face education to three PSWs and a RPN regarding when to use PPE, and the proper sequence of donning and doffing of PPE, including a return demonstration.

3) Maintain records of items #1 and #2 including the dates, facilitator, staff names and designation, signed attendance, content of education and evaluation methods.

4) Conduct audits on a daily basis for two weeks on all four home areas to include the following:

i) Staff and External contractors (where applicable) are in compliance with the home's hand hygiene program.

ii) Appropriate signage and soiled gown hampers are in place for residents on additional precautions.

iii) Staff and external contractors (where applicable) are donning/doffing PPE as per the home's PPE policy and procedures.

5) At the end of the two-week auditing period, the IPAC lead will analyze the results of the audits to identify gaps. The IPAC lead will develop and implement a plan to

communicate identified gaps to all staff members in the home and external contractors where possible, in addition to addressing those gaps.

6) Maintain records of items #4 and #5 including the auditor, the dates and times of the audits, the staff audited, results and analysis of the audits, and actions taken.

**Grounds**
The licensee 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.

A) The IPAC Standard for LTCHs, revised in September 2023, section 9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

The home's Hand Hygiene policy indicated that hand hygiene consists of either hand washing or the use of alcohol-based hand rub (ABHR), and all team members and visitors will practice hand hygiene according to the four moments of hand hygiene, including after removal of any Personal Protective Equipment (PPE).

Observations were conducted by Inspector #653 on January 3, 2024, on all four Home Areas (HAs). During the observations, an external contractor, eight PSWs, a

RPN, and a Maintenance Team Member did not practice hand hygiene according to the four moments of hand hygiene, including before initial resident environment contact, after resident environment contact, before donning PPE, after doffing PPE, and after contact with contaminated or soiled items.

The IPAC Lead stated that the staff and visitors were required to perform hand hygiene according to the four moments of hand hygiene.

**Sources:** The home's Hand Hygiene policy #IX-G-10.10 last revised November 2023; Inspector #653's observations; Interviews with the IPAC Lead, DOC, and other staff.

B) The IPAC Standard for LTCHs, revised in September 2023, section 9.1, indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

The home's Additional Precautions policy indicated that an element that comprises additional precautions is signage specific to the type of additional precautions.

A resident's progress notes indicated they developed a respiratory symptom and were placed on droplet/ contact precautions. On the following day, Inspector #653 observed that the droplet/ contact precautions signage was not posted on the resident's door.

The DOC acknowledged that the resident was supposed to be on droplet/ contact precautions, and this point of care signage should have been posted on the door.

**Sources:** The home's Additional Precautions policy #IX-G-10.70 last revised in

December 2021; Inspector #653's observations; Interviews with the DOC, and other staff.

C) The IPAC Standard for LTCHs, revised in September 2023, section 9.1, indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: f) Additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

The home's PPE policy indicated the recommended steps for putting on and taking off PPE.

Observations were conducted by Inspector #653 on January 3, 2024, on two HAs. During the observations, an external contractor, three PSWs, and a RPN did not adhere to the recommended steps for putting on and taking off PPE as per the home's PPE policy.

By not adhering to the home's IPAC policies and procedures related to hand hygiene, additional precautions, and PPE, there was an increased risk for the spread of infectious microorganisms amongst the residents and staff members.

**Sources:** The home's PPE policy #IX-G-10.20 last revised in March 2021; Inspector #653's observations; Interviews with the IPAC Lead, the DOC, and other staff. [653]

**This order must be complied with by** February 28, 2024

## 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.