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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Original Public Report

Report Issue Date: June 7, 2024
Inspection Number: 2024-1015-0002
Inspection Type: Proactive Compliance Inspection
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**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2024.06.07 09:53:15 -04'00'

Additional Inspector(s)
Daniela Lupu (758)
Kailee Bercowski (000734)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 10-12, 15-19, 22-25, and 29, 2024
The inspection occurred offsite on the following dates: April 17, 26, 2024

The following intake was inspected:

- Intake: #00113388 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Continence Care
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

i) A resident's plan of care related to transfers documented the resident required a specific device for all their transfers.

A Personal Support Worker (PSW) said that in recent months, they used a different type of device for all the resident's transfers.

An Registered Practical Nurse (RPN) said the resident should have been reassessed and their plan of care should have been revised when the resident was no longer able to use a specific type of device for their transfers.

ii) A resident was at risk for altered skin integrity and their plan of care documented the resident was to wear a specific pressure relieving device to offload the pressure from the altered skin integrity.

Observations showed that the resident did not wear the specific pressure relieving device.

The Director of Care (DOC) said the resident no longer needed to wear the specified pressure relieving device when they were in their wheelchair because their altered skin integrity had resolved.

Sources: observations of a resident, record review of a resident's clinical records, and interviews with staff. [758]

Date Remedy Implemented: April 18, 2024

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure a PSW used safe transferring techniques when they assisted a resident with a transfer.

Rationale and Summary:

A resident was transferred from the bed to their wheelchair in a method that they were not assessed for as per their plan of care.

The DOC said staff should not use a lower level of assistance than the level indicated in the resident's transfer assessments and care plan.

Staff not using safe transferring techniques when transferring the resident, put the resident at risk of harm.

Sources: A Critical Incident Report, a resident's clinical records, and interviews with a PSW, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident's responses and effectiveness of their pain management strategies was monitored.

Rationale and Summary:
The home's policy, "PRN Medication Administration and Documentation" said the attending Prescriber must be notified when administration of a same PRN (as needed) medication becomes regular or routine.

A resident had pain daily related to their medical conditions and their pain levels fluctuated during the day.

The resident said that when they were in a lot of pain, they would ask the registered staff for their PRN (as needed) pain medication for breakthrough pain.

The resident's Medication Administration Records (MARs) identified the resident was administered their PRN pain medication 118 times in 115 days.

A Registered Nurse (RN) said the resident would ask for their PRN pain medication daily and sometimes several times during the day. They acknowledged

the physician should have been notified about the resident's daily use of their PRN medication.

Failure to monitor the effectiveness of a resident's PRN medication may have caused the resident to have unrelieved pain.

Sources: Review of a resident's clinical records, and interviews with a resident and staff. [606]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that the lifts were being disinfected after every use.

The home's policy, "Equipment Cleaning, indicated that all shared equipment including mechanical lifts must be cleaned and disinfected after each use by team members using the item.

Several observations of a PSW during resident care identified that they did not clean and disinfect the mechanical lift after they had used the equipment between residents.

The PSW acknowledged that staff were to disinfect the lift after use and said they did not clean and disinfect the lift after they used it between residents.

Failure to clean and disinfect the lift increased the risk of contributing to the spread and transmission of an infectious disease.

Sources: Observations, review of the home's policy on Equipment Cleaning and interviews with staff. [606]

WRITTEN NOTIFICATION: Medication Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure three residents were administered their medications as scheduled.

Rationale and Summary:
The home's Medication Pass policy identified that all scheduled medications were administered within the standard timeframe of the medication pass established by the home. Prevailing practice was to administer medications within one hour before or after the scheduled time.

A) During an observation of a resident's medication administration pass, the resident's pain medication, scheduled for 1200 hrs was not administered until 1359 hrs after the RPN was alerted about the resident's medication by a Long-Term Care (LTC) homes Inspector. The RPN acknowledged that the resident received their pain medication late.

B) A resident's medication administration record (MAR) said the resident was to be administered an antibiotic medication three times a day.

The home's Medication Administration Audit Report for the specified date, said the resident received their antibiotic medication scheduled for 1700 hrs at 2132 hrs, over three hours later. The resident was concerned that they received their antibiotic medication late and reported their concern to a LTC homes Inspector.

C) A resident reported that their scheduled medications for 2000 hrs was not administered to them until 2324 hrs, which was over three hours late. An RPN acknowledged they did not administer the resident's medication as scheduled.

Failure to administer the residents' medications as scheduled may have may have compromised the therapeutic effect of the medications.

Sources: observations, record review of three residents' clinical records, and interviews with residents, and staff.[606]

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WRITTEN NOTIFICATION: Medication Management System

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that medication carts where drugs were stored were kept locked at all times, when not in use.

A i) During an observation on a dayshift, a medication cart was observed unlocked and unattended outside of the dining room. A registered staff had walked away after retrieving an item from the cart and did not lock the cart before walking away. A few minutes later, another registered staff approached the cart, completed post medication administration activities, and locked the medication cart.

ii) During an observation on a nightshift, a medication cart was observed unlocked and unattended in a hallway. The LTC homes Inspector informed a Registered Nurse (RN), who was in an office with the door closed.

The RN acknowledged that they left the medication cart unlocked and locked the medication cart in the presence of the Inspector.

Failure to ensure the medication carts were kept locked when not in use increased risk of unauthorized drug access.

Sources: observations, and interviews with staff. [606]