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: November 27, 2024

Inspection Number: 2024-1015-0004

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Tullamore Community, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19 - 21, 2024
The inspection occurred offsite on the following date(s): November 21, 2024

The following intake(s) were inspected:

- Intake: #00125382 - Related to an injury from unknown cause
- Intake: #00128730 - Alleged financial abuse of a resident
- Intake: #00130804 - Fall of of a resident resulting in an injury

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from financial abuse by a staff member.

For the purpose of this Act and Regulation, "financial abuse" means any misappropriation or misuse of a resident's money or property". O Reg 246/22. s. 2

Rationale and Summary:
A resident reported that they were missing money prompting an internal investigation.

The home's internal investigation substantiated claims of financial abuse and the resident was returned their money.

Financial abuse occurred when the staff member took the resident's money.

Sources: Critical Incident Report, review of the resident's medical record, review of the home's internal investigation , Interview with the resident ,Executive Director and other staff.

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee failed to comply with their pain management program for a resident.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that the home's pain management program policy related to the communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, is complied with.

Rationale and Summary:
The home's Pain & Symptom Management policy indicated that the nurse will screen for presence of pain and complete a pain assessment electronically.

The resident's pain was not assessed when they initially expressed it. Subsequently, an injury was identified a few days later.

Sources: The home's Pain & Symptom Management policy, resident's clinical health records, Critical Incident Report; Interviews with staff.

WRITTEN NOTIFICATION: Medication Management System

NC #003 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; and

The licensee failed to ensure that the written policy related to the Medication Administration Record (MAR) was implemented.

Rationale and Summary:
The home's Medication Administration Record (MAR) policy indicated that medication administration must be documented on the MAR immediately after administration by the health care staff.

A resident had an order for a pain management medication. The MAR indicated that, on multiple occasions, the administration of the pain medication was documented late.

Sources: Resident's clinical health records, Critical Incident Report; Interviews with staff.