Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 21, 2011	2011_170_2856_21Mar070817	Critical Incident L-00139

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Columbia Forest Long-Term Care Centre, 650 Mountain Maple Avenue, Waterloo ON N2V 2P7

Name of Inspector(s)/Nom de l'inspecteur(s)
Dianne Wilbee #170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to provision of care.

During the course of the inspection, the inspector spoke with: Executive Director, Registered Nurse (1), Personal Support Workers (2), Resident.

During the course of the inspection, the inspector: Reviewed home's investigation of critical incident, reviewed home's applicable policies, reviewed resident record, employee record as applicable to incident, reviewed orientation of new employees, reviewed Resident Non-Abuse policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

- Prevention of Abuse, Neglect and Retaliation

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.20(1)** Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Findings:
The home's written policy related to zero tolerance of abuse and neglect of residents was not complied with when a staff member neglected to provide a resident with care requirements.

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Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff are in compliance with the home's written policy for abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.23(2)** A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Findings:
The home has finalized an investigation of an incident and has not provided the MOHLTC every action taken.

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WN #3: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.24(1)2.** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:
A critical incident report was not submitted to the MOHLTC within the required immediate timeframe.

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WN #4: The Licensee has failed to comply with **O.Reg. 79/10 s.104(1)3v.** In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
v) the outcome or current status of the individual or individuals who were involved in the incident.

Findings:
The outcome or current status of the resident involved in the occurrence was not provided on the critical incident report.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Diane Filbee
Title: **Date:**	**Date of Report:** March 25, 2011