Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_750539_0003	003072-18, 008400-18, 009512-18, 016635-18, 020164-18, 025757-18, 032082-18, 033627-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Columbia Forest
650 Mountain Maple Avenue WATERLOO ON N2V 2P7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VALERIE GOLDRUP (539), FARAH_ KHAN (695), KRISTAL PITTER (735)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 11, 14, 15, 19, 20, 21, 22, and 26, 2019.

The following intakes were completed in this Critical Incident System Inspection:

Log #008400-18, Follow-up to Compliance Order #001 from RQI Inspection 2018-601532-0006 related to O. Reg 79/10, s. 52 (2), Pain Management.

Log #003072-18, Critical Incident Report (CIS) 2856-000003-18 – a submission for alleged improper care of a resident.

Log #009512-18, CIS 2856-000009-18, Log #032082-18, CIS 2856-000035-18, Log #033627-18, CIS 2856-000039-18 –submissions for incidents that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Log #025757-18, CIS 2856-000021-18- a submission for alleged resident Neglect.

The following intakes were completed; Log #016635-18, CIS 2856-000014-18 and Log #020164-18, CIS 2856-000020-18- incidents that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the inspection, the inspectors toured resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, and reviewed relevant policies and procedures pertaining to the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director(s) of Care, Associate Director(s) of Care, Environmental Service Manager, Behaviour Support Ontario Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 52. (2)	CO #001	2018_601532_0006	539

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. 6. (10) (b)

A Critical Incident System (CIS) report identified a fall which resulted in resident #012 receiving an injury on a specified date.

The Care Plan and Kardex for resident #012 directed staff to see the logo in the resident's bathroom for transfers, and did not identify the use of a fall prevention device.

On multiple observations during the inspection, a fall prevention device was found in resident #012's room. The logo posted in resident #012's bathroom directed staff to provide specified transfer assistance.

A PSW and a RPN reported that resident #012 had the fall prevention device. Two PSWs reported that the logo for transfers in resident #012's bathroom was wrong, and stated that resident #012 required more assistance than was identified on the logo.

The ADOC acknowledged that the fall prevention device had not been added to resident #012's plan of care, and the transfer logo in the bathroom did not correspond to the care staff were currently to provide.

The licensee failed to ensure that the plan of care for resident #012 with respect to falls prevention strategies and transfers was reviewed and revised at least every six months and at any other time when the resident's care needs changed. [s. 6. (10) (b)]

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 that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary., to be implemented voluntarily.

Issued on this 12th day of April, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.