



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des Soins  
de longue durée

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

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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## Public Copy/Copie du public

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_0002	008944-18, 009421-18, 009896-18, 010916-18, 011998-18, 012142-18, 012507-18, 014620-18, 015506-18, 020160-18, 026238-18, 026880-18, 033440-18	Complaint

### 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



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**The purpose of this inspection was to conduct a Complaint 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 Complaint Inspection:**

**Log #009896-18, IL-56946-CW and Log #010916-18, IL-57095-CW- related to temperatures in the home.**

**Log #012507-18, IL-57323-CW- a complaint regarding concern with Nursing and Personal Support Services and Housekeeping.**

**Log #009421-1, Critical Incident Report (CIS) 2856-000008-18- related to alleged resident abuse.**

**Log #026238-18, CIS 2856-000023-18 and Log #033440-18, CIS 2856-000036-18- related to alleged resident neglect.**

**Log #012142-18, IL-57274-CW, Log #008944-18, CIS 2856-000007-18, Log #011998-18, CIS 2856-000012-18, Log #026880-18, CIS 2856-000025-18, Log #015506-18, CIS 2856-000015-18, Log # 014620-18, CIS 2856-000013-18 and Log #020160-18, CIS 2856-000019-18 - submissions for alleged resident to resident abuse.**

**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:**



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**Accommodation Services - Housekeeping  
Contenance Care and Bowel Management  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours  
Safe and Secure Home  
Skin and Wound Care**

**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)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that resident #004 was protected from abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “sexual abuse” means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident System (CIS) report was submitted on a specified date, that stated resident #004 reported that resident #003 made sexually inappropriate gestures and comments toward resident #003.

A second CIS report was submitted on a specified date, that stated resident #004 informed the home that resident #003 had been sexually inappropriate on a second occasion.

Resident #003’s plan of care stated that the resident exhibited responsive behaviours towards other residents including sexually inappropriate behaviours in the past.

In an interview, a PSW recalled re-directing resident #003 during the second event. A RPN recalled that resident #003 continued to exhibit sexual behaviour at that time towards staff.

In an interview with the Inspector, resident #004 stated that they recalled the incident where resident #003 exhibited sexual behaviours towards them. The resident communicated that they were still afraid of other residents possibly exhibiting sexual behaviours towards them.

The licensee failed to ensure that resident #004 was protected from abuse by anyone. [s. 19. (1)]



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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 that residents are protected from abuse by anyone., to be implemented voluntarily.***

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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.**