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
Oct 24, 2019	2019_795735_0022	016578-19, 016733-19, 017133-19, 018091-19	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

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): October 7-10 and 15-18, 2019

Katherine Adamski, Inspector #753 was part of this inspection.

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

Log # 016578-19 related to personal support services, transferring and positioning technique.
Log # 016733-19 related to responsive behaviours and prevention of abuse and neglect.
Log # 017133-19 related to personal support services, transferring and positioning technique.
Log # 018091-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Behavioural Support Ontario Lead (BSO Lead), Dietary Services Supervisor (DSS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a resident.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, and reviewed relevant resident clinical records, policies, procedures, and investigative notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Mandatory Reporting of Resident Abuse or Neglect policy directed that all cases of suspected or actual abuse must be verbally reported immediately to the person in charge, followed by immediate reporting to the Director of the MLTC, in accordance with Critical Incident Reporting Requirements.

A) A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care (MLTC) reported alleged resident to resident verbal and physical abuse. No call was made to the MLTC after hours pager.

The Director of Care (DOC) reported that a Registered Nurse (RN) sent them an email reporting the incident of alleged abuse.

The DOC stated that staff were required to report any incidents of suspected abuse or neglect immediately, and stated that email communication was not acceptable.

B) A CIS report submitted to the MLTC reported an incident of alleged staff to resident neglect. No call was made to the MLTC after hours pager.

The DOC reported that a Registered Practical Nurse (RPN) did not call the on-call manager in response to the incident, and acknowledged that no call was made to the MLTC after hours pager.

The DOC acknowledged that both the aforementioned RN and RPN did not follow the home's policy for prevention of abuse and neglect, which states that incidents must be verbally reported to management immediately. The DOC reported that the expectation was that staff were to report any suspicions of abuse or neglect to the nurse in charge, the on-call manager, and the MLTC immediately as required.

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of alleged abuse in relation to reporting two incidents. [s. 20. (1)]

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 there is a written policy in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee, who was required to inform the Director of an incident under subsection 3.1 within 10 days of becoming aware of the incident, has failed to ensure that a written report to the Director was made, setting out the analysis and follow-up action with respect to the incident, including the long-term actions planned to correct the situation and prevent recurrence.

A CIS report submitted to the MLTC reported an incident that caused 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. The transfer status was changed for the resident.

The CIS report stated that long-term actions planned to correct the situation and prevent recurrence were to be determined. No further CIS report amendments were submitted to the Director.

The Executive Director (ED) reported that the CIS report was not amended to provide the Director with long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that a report was made to the Director, setting out the analysis and follow-up action with respect to the incident contained in the CIS report, including the long-term actions planned to correct the situation and prevent recurrence. [s. 107. (4) 4. ii.]

Issued on this 28th day of October, 2019

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

Original report signed by the inspector.