Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 14, 2021	2021_760758_0008	002515-21, 003011-21, 005996-21	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

DANIELA LUPU (758)

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): April 12-16, 2021 and April 19, 21-22, 2021.

The following intakes were completed in this Critical Incident (CI) inspection:

Log #002515-21, related to alleged neglect;

Log #003011-21, related to alleged abuse; and

Log #005995-21, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Falls Lead, Behavioural Support Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, and residents.

The inspector(s) toured the home, observed staff to resident interactions, infection prevention and control practices and safety conditions of the home. They also reviewed clinical records, the home's policies and procedures, and documents pertinent to the inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when two residents were reassessed because their plan of care related to responsive behaviours was not effective, that different approaches were considered in the revision of their plan of care.

A. Resident #001 was known to have specified responsive behaviours. Their care plan identified interventions that staff were to implement when the resident exhibited those behaviours.

Over a specified period of time, resident #001 displayed an increase in their responsive behaviours. On multiple occasions the interventions identified in their plan of care were not effective in responding to their behaviours.

No new interventions were implemented for the resident to address this. This resulted in the resident's hygiene deteriorating.

Sources: resident #001's clinical records, observations of resident #001, and interviews with registered staff, BSO Lead and other staff.

B. Resident #002 was known to have specified responsive behaviours. Their care plan identified interventions that staff were to implement when the resident exhibited those behaviours.

Over a specified period of time, resident #002's behaviours were not easily altered and on multiple occasions the interventions listed in their plan of care were ineffective in responding to their behaviours. No new interventions were implemented for the resident to address this until after their family reported the concerns to the home.

Failing to ensure that different approaches were considered when resident #002's plan of care was identified to be ineffective, resulted in their hygiene deteriorating and could have resulted in worsening of their health condition.

Sources: critical incident report, resident #002's clinical records, the home's investigative notes, observations of resident #002, and interviews with BSO Lead, DOC and other staff. [s. 6. (11) (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 when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 staff complied with their policy to promote zero tolerance of abuse and neglect of residents.

The home's policy "Resident Non-Abuse Program", stated that when an incident of alleged, suspected or witnessed abuse of a resident occurred, the resident should receive a full assessment and the assessment should be detailed and documented in their plan of care. The policy also stated that the resident's Substitute Decision Maker (SDM) should be notified immediately about the incident and the staff member involved should be immediately suspended until an investigation is completed by the home.

An incident of alleged abuse by a PSW towards a resident was reported to the registered staff. An assessment of the resident was not documented in their plan of care and the resident's Substitute Decision Maker (SDM) was not notified about the alleged incident until a day after it occurred. Additionally, the PSW allegedly involved in the incident continued to work in the home and provide care to other residents on the date when the alleged incident occurred despite allegations of abuse made towards them.

Staff not complying with the home's policy to promote zero tolerance of abuse and neglect of residents put the resident involved and other residents at potential risk of harm of the alleged PSW.

Sources: critical incident report, the home's investigative notes, resident's progress notes and assessments, the home's non abuse policy, interviews with registered staff, DOC and other staff. [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 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 that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) 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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse or neglect of residents occurred, immediately reported the suspicion to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A. A PSW allegedly witnessed another PSW yell at a resident, grab their wrist and abruptly take them to their room. This incident was reported to a registered staff immediately, however, it was not reported to the Director until a day later.

Sources: critical incident report, the home's investigative notes, resident's progress notes and interviews with the registered staff, DOC and other staff.

B. The home received a written communication that alleged neglect of a resident. The allegation was not reported to the Director until a day after it occurred.

The incidents of alleged abuse and neglect should have been reported immediately to the Director, but they were not reported until a day later.

Sources: critical incident report, the home's investigative notes, resident's progress notes and interviews with DOC and other staff. [s. 24. (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 a person who has reasonable grounds to suspect that 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 has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program, in relation to appropriate usage of Personal Protective Equipment (PPE) and assisting residents to perform hand hygiene when required.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22 and 30, 2020, Directive #3 was issued and revised on April 7, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

A) At the time of this inspection, four residents were on droplet and contact precautions for reasons related to Directive #3.

Public Health Ontario (PHO) Droplet and Contact precautions signage was posted on the door of these residents' rooms. The signage directed staff to wear a mask and eye protection when they were within two meters of these residents and to disinfect or discard this equipment prior to exiting these residents' rooms.

On separate occasions, four staff members were observed providing direct care to and being within two meters of the four residents on droplet and contact precautions, while in their rooms. Four of these staff did not discard their mask and three of them did not disinfect their eye protection prior to exiting these residents' rooms.

The home's IPAC Lead stated these staff should have discarded their masks and disinfected their eye protection prior to exiting these residents' rooms to prevent the potential spread of viruses and bacteria throughout the home.

B) On two separate occasions on two resident home areas, multiple residents were not encouraged, reminded or assisted to perform hand hygiene by staff members before or after their lunch meal. The home's IPAC Lead stated that staff should have reminded or assisted the residents with hand hygiene before and after meals as per the home's IPAC policy.

Failing to ensure staff doffed and disinfected their PPE when required and assisted residents to perform hand hygiene before and after meals increased the risk of transmission of viruses and bacteria to residents, staff and visitors throughout the home.

Sources: observations of meal service, the home's IPAC policy, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, (November 2012); Directive #3 (2021), IPAC Recommendations for Use of PPE for Care of individuals with Suspect or Confirmed COVID-19 (January 2021), Public Health Ontario (PHO), Droplet and Contact Precautions signage, PHO signage for Applying and Removing PPE and interviews with IPAC Lead and other staff. [s. 229. (4)]

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 staff participate in the implementation of the home's Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 21st day of May, 2021

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

Original report signed by the inspector.