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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2021	2021_872218_0021	017125-21	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

APRIL RACPAN (218)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 31, September 1, 7 -10, 2021.

-Log #009863-21/Critical Incident System (CIS) Report and a Complaint Log #009888-21 related to an elopement incident.

Please refer to Inspection #2021_872218_0016 for the original report of this inspection. The inspection was completed concurrently with CI Inspection #2021_872218_0017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Infection Prevention and Control (IPAC) Lead, the Environmental Services Manager, the Physiotherapist (PT), Registered staff, Housekeeping staff, Behavioural Supports of Ontario (BSO) staff, Surveillance Screeners, and Personal Support Workers (PSW).

During the course of the inspection, the inspectors conducted a tour of the resident home areas (RHAs), observed IPAC practices, resident care provision, resident/staff interactions, and completed resident and staff interviews. The inspectors also reviewed clinical health records, posting of required information, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- 1 WN(s)
- 0 VPC(s)
- 1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

The home’s front entrance doors were monitored and operated by designated staff

members that included, but were not limited to security screeners hired by a third party agency. They were responsible for screening individuals to come in and out of the home, including residents.

The following elopement incidents took place involving three different residents on separate occasions between April - July 2021:

A) A resident exited the building through the home's front entrance doors when the designated screener mistook them for a family member and allowed them to exit.

B) A resident exited the home through the front doors and went missing for a period of time. Staff were not aware that the resident had left the building, until they were notified by members in the community. While out of the home, the resident sustained an injury. Multiple staff members shared that it was very likely that the designated screener allowed the resident to go outside without identifying or recognizing them, or that the resident followed someone outside.

C) A resident eloped from the home on two occasions on the same day. On one occasion, they were found outside of the home's premises. A staff member recalled that the screener either let the resident out through the front doors or they followed a staff member outside.

All three residents remain at risk for elopement and have continued wandering behaviours. DOC #101 said that screeners were responsible for the surveillance of residents coming in and out of the home and ensuring that the front entrance doors were secured to prevent wandering residents from leaving the home. The designated screeners were not provided with education related to the home’s policies on doors and on the home’s expectations for the surveillance of residents at the front entrance.

Failure to ensure that the home’s front entrance was safe and secured, placed wandering residents at risk for elopement and harm.

Sources: CIS report, LTC – Door Alarms (Policy CARE10.O010.07 last reviewed March 31, 2019), Revera’s Covid-19 Playbook guidance document s.6.6 “Building and Layout”, progress notes, resident and front entrance observations, interviews with management staff, designated screeners, and others. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : APRIL RACPAN (218)

Inspection No. / No de l'inspection : 2021_872218_0021

Log No. / No de registre : 017125-21

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Oct 27, 2021

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

LTC Home / Foyer de SLD : Columbia Forest
650 Mountain Maple Avenue, Waterloo, ON, N2V-2P7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lilibeth Medina

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To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with the Long-Term Care Homes Act (LTCHA) s. 5.

Specifically, the licensee must ensure that:

1) The home's front entrance is safe and secured.

2) Identify all residents at risk for wandering, exit-seeking, and elopement and have their names placed on a "High Risk Identification Form" as per the home's Wandering and Elopement policy, The list must be made available to those individuals responsible for monitoring the home's front entrance.

3) All designated screeners, including the Receptionist(s), the Rapid Antigen Testing staff, and any other staff responsible for monitoring the home's front entrance, are provided with training and education on the home's policies related to Door Alarms, Wandering and Elopement, Code Yellow, and on the surveillance process for monitoring residents at the front entrance.

4) A documented record of the education and training will be kept at the home and include the names of the individuals who attended the training, the name(s) of the person(s) who provided the training, the date(s) and content of the training provided, and any other actions taken.

Grounds / Motifs :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

The home's front entrance doors were monitored and operated by designated staff members that included, but were not limited to security screeners hired by a third party agency. They were responsible for screening individuals to come in and out of the home, including residents.

The following elopement incidents took place involving three different residents on separate occasions between April - July 2021:

A) A resident exited the building through the home's front entrance doors when the designated screener mistook them for a family member and allowed them to exit.

B) A resident exited the home through the front doors and went missing for a period of time. Staff were not aware that the resident had left the building, until they were notified by members in the community. While out of the home, the resident sustained an injury. Multiple staff members shared that it was very likely that the designated screener allowed the resident to go outside without identifying or recognizing them, or that the resident followed someone outside.

C) A resident eloped from the home on two occasions on the same day. On one occasion, they were found outside of the home's premises. A staff member recalled that the screener either let the resident out through the front doors or they followed a staff member outside.

All three residents remain at risk for elopement and have continued wandering behaviours. DOC #101 said that screeners were responsible for the surveillance of residents coming in and out of the home and ensuring that the front entrance doors were secured to prevent wandering residents from leaving the home. The designated screeners were not provided with education related to the home's policies on doors and on the home's expectations for the surveillance of residents at the front entrance.

Failure to ensure that the home's front entrance was safe and secured, placed wandering residents at risk for elopement and harm.

Sources: CIS report, LTC – Door Alarms (Policy CARE10.O010.07 last reviewed March 31, 2019), Revera's Covid-19 Playbook guidance document s.6.6

"Building and Layout", progress notes, resident and front entrance observations, interviews with management staff, designated screeners, and others.

An order was made by taking the following factors into account:

Severity: The licensee not ensuring that the home's front entrance was safe and secure placed wandering residents at actual risk of harm and additional elopement incidents.

Scope: This non-compliance was widespread because three out of three residents with wandering behaviours had eloped from the home through the front entrance doors.

Compliance History: In the last 36 months, eight Written Notifications (WN) and seven Voluntary Plan of Corrections (VPC) were issued to the home related to different sections of the legislation. (218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 24, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of October, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : April Racpan

Service Area Office / Bureau régional de services : Central West Service Area Office