Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: December 16, 2022	
Inspection Number: 2022-1341-0001	
Inspection Type: Critical Incident System (CIS)	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Columbia Forest, Waterloo	
Lead Inspector Alicia Campbell (741126)	**Inspector Digital Signature** Alicia Campbell Digitally signed by Alicia Campbell Date: 2022.12.19 11:25:03 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 30-December 1, 2022, and December 6-8, 2022.

The following intake(s) were inspected:

- Intake: #00008889, CIS #2856-000015-22 -related to a fall resulting in transfer to hospital and injury.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 s. 102 (2) (b)

The Licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard, as issued by the Director, was implemented.

The IPAC Standard for Long-Term Cares Homes, dated April 2022, section 9.1 states at a minimum, additional precautions shall include point of care signage indicting that enhanced IPAC control measures are in place.

Specifically, the licensee failed to post additional precaution signage at the door to resident #005's room. Registered Practical Nurse (RPN) #108 and IPAC lead/interim Director of Care (DOC) confirmed resident #005 was being isolated and additional precautions signage should have been posted.

On December 6, 2022, additional precautions signage was observed posted on resident #005's door.

Date Remedy Implemented: December 6, 2022.

[741126]

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (1) 2.

The licensee has failed to comply with strategies to manage the pain of resident #001 post fall.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management

program, at a minimum, provides for strategies to manage pain for residents and must be complied with.

Rationale and Summary

On a specified date, resident #001 had a fall that resulted in an injury. The resident began experiencing pain, which was reported to and documented by Registered Nurse (RN) #107. For approximately seven hours, the residents pain went untreated.

RN #105 and IPAC lead/interim DOC both indicated that the pain resident #001 experienced at this time should have been treated.

Failure to treat resident #001's pain for approximately seven hours may have caused resident #001 unnecessary suffering and discomfort.

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