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
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: April 4, 2024
Inspection Number: 2024-1341-0003
Inspection Type: Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Columbia Forest, Waterloo

Lead Inspector	**Inspector Digital Signature**
Daniela Lupu (758)	Daniela Lupu Digitally signed by Daniela Lupu Date: 2024.04.09 09:18:12 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 25-27, 2024
The inspection occurred offsite on the following date: March 28, 2024

The following intake was inspected:

- Intake #00110312, related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that a resident's interventions under Falls Prevention and Management Program were documented.

Rationale and Summary

A resident's plan of care related to falls prevention included checks at specified intervals of time to ensure falls prevention interventions were in place. These checks were to be documented in the resident's Point of Care (POC).

On one occasion, the resident had a fall and sustained an injury. The checks prior to the resident's fall and all checks during that shift were not documented as indicated in the resident's plan of care. Additionally, in one-month period, on multiple occasions during all shifts, the checks were not documented as required.

The Director of Care (DOC) said that the interventions should have been documented as specified in the resident's plan of care.

By not documenting the checks as indicated in the resident's plan of care staff may not be aware if the falls interventions were in place as required and made it difficult to evaluate the effectiveness of this intervention.

Sources: a critical incident report, a resident's clinical records, and interviews with a Personal Support Worker (PSW) and the DOC. [758]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) 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,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that the critical incident report related to a resident's fall, included the long-term actions to prevent recurrence.

Rationale and Summary

A critical incident related to a resident's fall resulting in transfer to a hospital and a change in the resident's condition was received by the Ministry of Long-Term Care (MLTC).

Following the resident's return from the hospital, multiple interventions to prevent

recurrence were implemented. However, the critical incident report was not amended with these actions.

The DOC acknowledged the report was not amended to include the above information, as required.

Sources: a critical incident report, a resident's clinical records, and an interview with the DOC. [758]