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
Telephone: (888) 432-7901

Public Report

Report Issue Date: January 30, 2025

Inspection Number: 2025-1341-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21-23, 27-30, 2025

The following intake(s) were inspected:

- Intake: #00132028 - Improper care of a resident during toileting
- Intake: #00132081 - Unexpected death of a resident
- Intake: #00134124 - Improper transfer of a resident resulting in fall

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a Registered Nurse (RN) complied with the care set out in a resident's plan of care.

Sources: Clinical record review for the resident, interview with an RN and physician.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to ensure that an incident of improper care of a resident that resulted in risk of harm to the resident was immediately forwarded to the Director.

A Personal Support Worker (PSW) improperly transferred a resident out of bed, resulting in a resident fall. This incident was not reported to the Director until the following day.

Sources: Clinical record review for the resident, CI #2856-000041-24, interview with the resident and ADOC/falls leads.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a PSW used safe transferring techniques when assisting a resident out of bed.

A PSW improperly transferred a resident out of bed without the assistance of a second staff member or a mechanical lift, resulting in a resident fall. The resident was not injured.

Sources: Clinical record review for the resident, CI #2856-000041-24, interview with the resident and ADOC/falls lead.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (iii)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,

The licensee failed to ensure that a PSW provided a resident an incontinence care

product that promoted their comfort, ease of use, dignity and good skin integrity.

A resident was found to be "double briefed" by a PSW. The resident's skin was reddened due to the improper use of the products.

Sources: CI #2856-000031-24, clinical record review for the resident, and interview with an RN and DOC

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

As outlined in the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 7.3 (b) stated that the IPAC lead is responsible for ensuring that audits are performed, at least quarterly, to ensure that all staff can perform the IPAC skills required for their role.

The licensee failed to ensure that the IPAC lead completed these department-specific audits for all IPAC related tasks of each staffing role on a quarterly basis.

Sources: Interview with the IPAC lead, review of IPAC audits.