



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

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

London Service Area Office
291 King Street, 4th Floor
London ON N6B 1R8

Bureau régional de services de London
291, rue King, 4^{ème} étage
London ON N6B 1R8

**Ministère de la Santé et des Soins de
longue durée**

Telephone: 519-675-7680
Facsimile: 519-675-7685

Téléphone: 519-675-7680
Télécopieur: 519-675-7685

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection November 1 and 2, 2010	Inspection No/ d'inspection 2010_170_2856_01Nov081555	Type of Inspection/Genre d'inspection Critical Incident L-01541
---	---	---

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Columbia Forest Long-Term Care Centre, 650 Mountain Maple Avenue, Waterloo, ON N2V 2P7

Name of Inspector(s)/Nom de l'inspecteur(s)
Dianne Wilbee #170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to a resident's fall.

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Assistant Director of Care (2), Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector: Reviewed of Critical Incident report, clarified details of the incident, reviewed resident record, observed resident, reviewed related policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

- Critical Incident
- Falls Prevention

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)
Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)4

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to be cared for in a manner consistent with his or her needs.

Findings:

A resident known to be cognitively-impaired, to be at a high risk for falls and to have unpredictable behaviours sustained an injury related to a fall during the provision of care.

Inspector ID #: 170

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 resident care is provided in a manner consistent with the resident's needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.30(2)

(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.

Findings:

Documentation of the assessment of a resident post a fall involving an injury did not provide detailed information regarding the outcome of the assessment.

Inspector ID #: 170

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 documentation of assessments, to be implemented voluntarily.



Ministry of Health and
Long-Term Care

Ministère de la Santé et
des Soins de longue durée

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

Rapport
d'inspection prévue
le *Loi de 2007 les
foyers de soins de
longue durée*

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. <i>Dianne Kilbee</i>
Title: _____ Date: _____	Date of Report: November 10, 2010