Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2014	2014_271532_0025	L-000520-14	Critical Incident System

Licensee/Titulaire de permis

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
650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7

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

NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 09, 10 and 14, 2014

Seven concurrent CIS inspections were completed 000023-14, 000027-14, 001062-14, 000024-14, L-000587-14, L-000520-14, L-000510-14

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant Director of Cares (ADOC), Education Manager, Program Manager, Behavioural Support Ontario (BSO) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family.

During the course of the inspection, the inspector(s) toured the resident home areas, review medical records, relevant policies and procedures as well investigation reports, observed the provision of care and interaction between staff and residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be protected from abuse was fully respected and promoted.

A) Clinical record and home internal investigation notes were reviewed and revealed that an identified resident was on the way to the dining room when an incident involving a Personal Support Worker (PSW) occurred.

Resident became very upset.

The Registered Practical Nurse (RPN) that was examining the situation at the time approached the PSW and asked if resident had reported any concerns to the PSW. The PSW as per internal investigation notes confronted the resident.

The Executive Director in an interview acknowledged that the PSW’s behaviour was not in keeping with resident's right and staff should not have confronted the resident.

B) Clinical record review stated that an identified resident reported to staff that they do not like an identified PSW. The resident informed staff that the PSW does not listen and respect resident's wishes and was rude with the resident.

In an interview the resident confirmed that the identified PSW treated the resident “meanly” and "ignored" their wishes and “argued” with the resident.

Internal investigation confirmed that the identified PSW admitted to saying "no" to a resident's preference and further admitted to not having enough time to feed the resident.

The ED in an interview acknowledged that the PSW's behaviour was not in keeping with resident's right. [s. 3. (1) 2.]

Additional Required Actions:

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 every resident is protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect a resident from abuse by anyone and free from neglect by the licensee or staff in the home.

A review of the clinical record revealed that an identified resident was heard in their room. A Personal Support Worker (PSW) went to check on the resident and found another identified resident abusing the resident.

A review of the clinical record revealed that the identified resident sustained injuries.

Review of the clinical record stated that a similar incident had occurred earlier where the same identified resident had wandered in to another resident's room and had injured the resident.

Review of clinical record revealed that the identified resident was being monitored for wandering, however, a review of the documentation revealed that monitoring was not completed until after the incident occurred.

In an interview the two Assistant Director of Care (ADOC) confirmed the expectation for staff was to document the tasks as they occurred to ensure accurate documentation.

The ADOC confirmed that the identified resident ended up in the wrong room.

The licensee was aware of the risk that the identified resident may be a threat to other residents and failed to protect resident from abuse. [s. 19. (1)]

Additional Required Actions:

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 each resident is protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 6th day of August, 2014

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