Ontario

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015	2015_215123_0014	017245-15, H-001933-15	Critical Incident System

Licensee/Titulaire de permis

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

Long-Term Care Home/Foyer de soins de longue durée

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

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

MELODY GRAY (123)

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): September 1, 2015

Concurrent inspection: 2015_215123_0013/H-002851-15

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), registered staff, program staff, the Associate Director of Care (ADOC) and the Directors of Care (DOCs)

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents as evidenced by:

A. The record of resident #200 was reviewed and it was noted that the resident was wheelchair dependent and at a high risk for falls. The resident required the assistance of two staff members for transferring and for toileting.

The review of the resident's record and the home's records including the Critical Incident reports indicated that in June 2015, one staff member attempted to toilet the resident without the assistance of a second staff member. The resident fell. The resident was not injured as a result.

Documentation in the resident's record and the home's records also noted that in July 2015, the resident was toileted and transferred back to their wheelchair by one staff and slid off the wheelchair and onto the floor. The resident was not injured as a result.

The Director of Care (DOC) and the Associate Director of Care (ADOC) were interviewed and they confirmed that the the staff did not use safe transferring techniques when assisting resident #200.

B. The record of resident #300 was reviewed and it indicated that the resident was wheelchair dependent; had a high risk for falls and required the assistance of one staff member and a walker for transferring.

The resident's record and the home's records including Critical Incident report were reviewed and it was noted that in January 2015, the resident was assisted to transfer by a staff member without the use of the walker. The resident fell onto the floor. The resident was sent to the hospital for further assessment and did not have any injury from the fall.

The DOC and the ADOC were interviewed and they confirmed that the staff did not use safe transferring techniques when assisting resident #300. [s. 36.]

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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 20th day of November, 2015

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

Original report signed by the inspector.