



**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
Direction de l'amélioration de la
performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11ième étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|--------------------------------|--|
| Dec 23, 2015 | 2015_215123_0013 | 016824-15 | Complaint |

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



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Complaint inspection.

**This inspection was conducted on the following date(s): August 19, 20, 21, 24, 25,
September 1 & November 26, 2015.**

Concurrent inspection: 2015_215123_0014/017245-15,001427-15.

**During the course of the inspection, the inspector(s) spoke with the Directors of
Care (DOCs), the Assistant Director of Care (ADOC), the physician and registered
staff.**

**The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan as evidenced by:

The record of resident #100 was reviewed including; the Re-Admission Order Forms and the Physician's Digiorder of May and June 2015. The May 2015 Physician's Digiorder indicated that if resident's temperature was at or above a certain temperature, the staff were to call the physician or Nurse Practitioner (NP).

The review of the Progress Notes and the vital signs monitoring sheets revealed that in June 2015 the resident was noted to have a temperature. No documentation was found in the resident's record which indicated that the staff called the physician or NP when the resident's temperature reached above the specified Celsius as specified in the plan of care. The physician was called several hours later when the resident's temperature was noted to have increased further and they had other symptoms.

The Directors of Care (DOCs) were interviewed and they confirmed that, the staff did not call the physician or the NP as set out in the plan of care related to the resident's temperature when it was at or above the specified Celsius. [s. 6. (7)]

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 the care set out in the plan of care is provided to the residents as specified in the plans, 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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 22nd day of February, 2016

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

Original report signed by the inspector.