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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 2, 2017	2017_574586_0001	000840-17	Resident Quality Inspection

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

JESSICA PALADINO (586), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 30 and 31, 2017

The following Complaint Inspections were completed concurrently with the RQI:
007309-16 - Prevention of Abuse & Neglect
030056-16 - Prevention of Abuse & Neglect
033000-16 - Resident's Bill of Rights; Maintenance; Housekeeping
033606-16 - Medication Administration

000896-17 - Personal Support Services
000971-17 - Staffing; Continence Care & Bowel Management; Personal Support Services

The following Critical Incident System (CIS) Inspections were completed concurrently with the RQI:
027771-15 - Prevention of Abuse & Neglect
029966-15 - Personal Support Services
035737-15 - Falls Prevention
036442-15 - Prevention of Abuse & Neglect
010390-16 - Prevention of Abuse & Neglect
017315-16 - Prevention of Abuse & Neglect
024775-16 - Prevention of Abuse & Neglect
024780-16 - Prevention of Abuse & Neglect
027025-16 - Prevention of Abuse & Neglect
027159-16 - Prevention of Abuse & Neglect
027757-16 - Medication Administration
028181-16 - Falls Prevention
028999-16 - Prevention of Abuse & Neglect
035259-16 - Prevention of Abuse & Neglect
002158-17 - Prevention of Abuse & Neglect
002156-17 - Prevention of Abuse & Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Directors of Care (DOC), Nurse Managers (NM), Environmental Service Manager (ESM), Personal Support Workers (PSW), Registered Nursing staff, residents, families and substitute decision makers (SDM).

The inspectors observed care provision throughout the home, reviewed clinical records, toured the home, observed medication administration and medication storage areas, observed recreation activities, reviewed relevant policies and procedures, observed resident-staff interactions, observed posting of required information and observed general maintenance.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **2 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 resident #110 was transferred safely.

On an identified date in 2015, PSW #002 was assisting resident #110 with toileting when the resident lost their balance and fell, causing injury.

The resident's documented plan of care indicated that the resident required two staff for toileting. Review of the home's internal investigation notes, as well as interview with the Administrator on January 24, 2017, confirmed that the resident was toileted with the assistance of only one staff member, causing injury to the resident. Staff did not use safe transferring techniques to assist resident #110. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

On an identified date in 2016, resident #012 did not receive a specific number of medications during the evening medication pass. These medications were prescribed by the physician; however, the resident did not receive them. The DOC confirmed the registered staff member did not provide the medication to the resident. The documentation provided by the home, including a medication incident report and progress notes also confirmed the medication was not provided. [s. 131. (2)]

Issued on this 2nd day of February, 2017

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

Original report signed by the inspector.