Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_760758_0011	001386-20, 003502-20, 003503-20, 005243-20, 014784-20, 014842-20	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

DANIELA LUPU (758), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10-14 and 17-20, 2020.

The following intakes were completed in this Complaint inspection:

Log #001386-20, related to responsive behaviours and nutrition;

Log #005243-20, related to skin and wound;

Log #003502-20, related to compliance order (CO) #001 from inspection # 2020_793743_0001 related to policies to be followed;

Log #003503-20, related to compliance order (CO) #002 from inspection # 2020_793743_0001 related to pain management;

Log #014842-20, related to an injury and significant change in condition;

The following Critical Incident System intake related to the same issue (injury and significant change in condition) was inspected during this complaint inspection:

Log # 014784-20.

PLEASE NOTE: This complaint inspection was completed concurrently with Critical Incident inspection #2020_760758_0012.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Directors of Care (Co-DOC), Assistant Director of Care (ADOC), Behaviour Support of Ontario Lead (BSO), Physiotherapist (PT), Physiotherapist Assistants (PTA), a Restorative Aide (RA), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Substitute Decision Makers (SDM), and the residents.

The inspector(s) reviewed relevant residents' clinical records, plans of care, pertinent policies and procedures, the home's investigative records, relevant training records, and observed resident and staff interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2020_793743_0001	532

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	Légende 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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

This inspection was completed to follow up on compliance order (CO) #002 from inspection # 2020_793743_0001, issued on February 13, 2020, with a compliance due date of March 20, 2020.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to resident #004's injury and significant change in condition.

Resident #004's clinical records documented multiple dates and times when resident #004 complained of pain or discomfort to a specific area since the day of their admission, and in the days leading to their multiple transfers to the hospital.

The home's investigative notes documented multiple staff members' statements and interviews indicating that resident #004 complained of pain with movement and during care.

Co Director of Care (Co-DOC) #112 said the Comprehensive Pain Assessment located in Point Click Care (PCC) was the home's clinically appropriate assessment instrument specifically designed for pain.

Registered staff #105 said that when a Personal Care Provider (PCP) reported that a resident experienced pain, they would conduct a comprehensive pain assessment to determine the root cause of the pain, the location, intensity and they would ask the resident to move the affected part of the body to determine the pain level.

Review of resident #004's documentation report for pain, on an identified month, indicated that PCPs documented that the resident was noted experiencing pain on multiple dates and times.

On multiple occasions, prior to their second transfer to the hospital, the resident experienced pain with movement and during care and reported to PCPs. The registered staff completed numerical pain scales and Pain Assessments in Advanced Dementia (PAINAD) and did not note pain as the resident was resting. No comprehensive pain assessments were completed on any of these occasions to determine when the resident's pain occurred.

Assistant Director of Care (ADOC) #101 said that comprehensive pain assessments were not completed because the resident did not complain of pain when asked by the registered staff. However, the resident typically complained of pain during care and the PAINAD did not capture movement.

Resident #004's clinical records after their second return from the hospital documented that the resident continued to complain of pain during care and with movement.

PCP #102 and #103 said that if the resident complained of pain or if they noted any signs of pain, they would report to the registered staff and document in the Point of Care (POC).

Co-DOC #112 said when PCPs reported pain, the registered staff should gather adequate information about resident's pain from PCPs, if they were not able to assess the resident at the time when the pain was reported.

On an identified date and time, a PCP documented that resident #004 had pain.The PAINAD or numerical pain scale was not completed until approximately five hours later when the pain medication was administered.

On the second day, a PCP documented that the resident had pain in two occasions. The PAINAD was not completed until approximately four hours later, at the time of the pain medication administration.

No comprehensive pain assessments were completed when the resident complained of pain and the initial interventions were not effective. The registered staff did not assess the resident's pain until the time of their scheduled pain medication administration.

Co-DOC #111 said that comprehensive pain assessments had not been completed as the resident did not complain of pain when asked by the registered staff.

Resident #004 was transferred to the hospital for assessment. Four days after their return from the hospital, it was determined that resident #004 had an injury for which they were transferred again to the hospital. The resident had a significant change in their condition as a result of the injury.

The licensee failed to ensure that when resident #004’s pain was not relieved by initial

interventions, resident #004 was assessed using a clinically appropriate assessment instrument specifically designed for pain. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent and has been assessed as being potentially continent of bowel, received assistance and support from staff to become continent or continent some of the time.

When an identified resident asked to use the toilet, PCP #103 told them that they would change their incontinent product. The resident was immediately assessed by the physiotherapist (PT) #108 and was assisted to the toilet.

The resident said that before their admission they used to go to the toilet.

The resident's admission clinical records, documented that they were incontinent of bladder and continent of bowel.

The resident's Continence Observation Form on admission, indicated that during a three-day observation period, the resident was both continent and incontinent of bowel.

PCP #102 and #103 said that the resident was not able to use the toilet after their admission due to a change in their condition, and they changed their incontinent product in bed.

Registered staff #107 said that after being toileted the first two days after their admission, the staff started changing the resident’s incontinent product in bed.

The resident was not assessed or offered alternatives to maintain their continence until after the Long-Term Care (LTC) Homes Inspector’s observation.

Registered staff #107 said that alternatives to maintain the resident's bowel continence had not been considered.

Co-DOC #111 said that the Occupational Therapist (OT) assessed the resident the next day for alternatives to use the toilet.

The licensee failed to ensure that a resident who was incontinent and was assessed as being potentially continent of bowel some of the time, received assistance and support from staff to become continent or continent some of the time. [s. 51. (2) (d)]

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 each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

Issued on this 23rd day of September, 2020

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DANIELA LUPU (758), NUZHAT UDDIN (532)
Inspection No. / No de l’inspection :	2020_760758_0011
Log No. / No de registre :	001386-20, 003502-20, 003503-20, 005243-20, 014784-20, 014842-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 18, 2020
Licensee / Titulaire de permis :	Villa Forum 175 Forum Drive, MISSISSAUGA, ON, L4Z-4E5
LTC Home / Foyer de SLD :	Villa Forum 175 Forum Drive, MISSISSAUGA, ON, L4Z-4E5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Celia Lisi

To Villa Forum, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_793743_0001, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s.52 (2) of the O.Reg 79/10.

Specifically, the licensee must:

1) Ensure that when resident #004's or any other residents' pain is not relieved by initial interventions, the residents are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

2) Ensure that appropriate actions are taken to relieve resident #004's or any other residents' pain until the residents no longer require assessments or actions to be taken to manage their pain.

3) If registered staff are unable to assess resident #004's or any other residents' pain as soon as it is reported, they gather and document the information from the PCPs about the residents' pain to include the time when the pain started and a description of any movement or activity causing pain.

4) Ensure that a process is developed and implemented between the personal care providers (PCP) and the registered staff when resident #004 or any other residents report or exhibit signs and symptoms of pain.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate

assessment instrument specifically designed for this purpose.

The licensee has failed to comply with compliance order (CO) #002 from inspection # 2020_793743_0001, issued on February 13, 2020, with a compliance due date of March 20, 2020.

The licensee was ordered to:

a) Ensure that when resident #003 and any other residents' pain is not relieved by initial interventions, that resident #003 and any other resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose; and that appropriate actions are taken to relieve resident #003 and any other residents' pain. The monitoring must be documented and continue until resident #003 and any other residents are no longer required to be assessed or action required to manage their pain.

b) Ensure registered staff receive education and demonstrate their understanding of the home's clinically appropriate assessment instrument specifically designed for pain. Documentation of the completed education should be kept in the home.

The licensee completed step b) in CO #002.

The licensee failed to complete step a) regarding ensuring that when the pain is not relieved by the initial interventions, the residents are assessed using a clinically appropriate assessment instrument specifically designed for this purpose; and that appropriate actions are taken to relieve residents' pain.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to resident #004's injury and significant change in condition.

Resident #004's clinical records documented multiple dates and times when resident #004 complained of pain or discomfort to a specific area since the day of their admission, and in the days leading to their multiple transfers to the hospital.

The home's investigative notes documented multiple staff members' statements

and interviews indicating that resident #004 complained of pain with movement and during care.

Co Director of Care (Co-DOC) #112 said the Comprehensive Pain Assessment located in Point Click Care (PCC) was the home's clinically appropriate assessment instrument specifically designed for pain.

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Resident #004's clinical records after their second return from the hospital documented that the resident continued to complain of pain during care and with movement.

PCP #102 and #103 said that if the resident complained of pain or if they noted any signs of pain, they would report to the registered staff and document in the Point of Care (POC).

Co-DOC #112 said when PCPs reported pain, the registered staff should gather adequate information about resident's pain from PCPs, if they were not able to assess the resident at the time when the pain was reported.

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Co-DOC #111 said that comprehensive pain assessments had not been completed as the resident did not complain of pain when asked by the registered staff.

Resident #004 was transferred to the hospital for assessment. Four days after their return from the hospital, it was determined that resident #004 had an injury for which they were transferred again to the hospital. The resident had a significant change in their condition as a result of the injury.

The licensee failed to ensure that when resident #004's pain was not relieved by initial interventions, resident #004 was assessed using a clinically appropriate assessment instrument specifically designed for pain. [s. 52. (2)]

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had ongoing non-compliance to the same subsection of the LTCHA that included:
-compliance order (CO) #002 issued February 13, 2020, (2020_793743_0001)

Additionally, the LTCH has a history of one other compliance order in the last 36

months. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 19, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daniela Lupu

Service Area Office /
Bureau régional de services : Central West Service Area Office