Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: January 12, 2023	
Inspection Number: 2023-1340-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: Villa Forum	
Long Term Care Home and City: Villa Forum, Mississauga	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.01.12 14:58:45 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following dates: January 4-6, 10, 2023.

The following intakes were inspected:
-Intake: #00012560 follow-up to Compliance Order (CO) #001 of inspection #2022-1340-0001 with a Compliance Due Date (CDD) of December 8, 2022, related to medication management system.
-Intake: #00014250 related to falls prevention and management.
-Intake: #00014414 related to an injury from unknown cause.

The following intake was completed:
-Intake: #00013855 related to an injury from unknown cause.

Previously Issued Compliance Order

The following previously issued Compliance Order was found **to be** in compliance:

Order #001 from inspection #2022-1340-0001 related to O. Reg. 79/10, s. 114 (3) (a), inspected by Romela Villaspir (653).

The following **Inspection Protocols** were used during this inspection:

Medication Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when their care needs changed.

Rationale and Summary

A resident was at risk for falls and their care plan indicated that they used an assistive device for mobility.

The resident was placed on isolation due to clinical symptoms, and during the isolation period, the staff provided the resident with a temporary device for mobility inside the room.

There was no information on the resident's plan of care related to the use of a temporary device during their isolation period.

The resident had two unwitnessed falls while they were on isolation.

By not reassessing the resident, and reviewing and revising the plan of care, there was potential for the staff to not incorporate the resident's falls risk while using the temporary device.

Sources: Resident's clinical health records; Interviews with PSWs, and a Registered Nurse (RN). [653]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff upon their return from hospital on two occasions.

Rationale and Summary

A resident was sent to hospital on two occasions due to a change in their health condition.

A skin assessment was not completed by the registered staff upon the resident's return from hospital. By not completing a skin assessment, there was a potential risk for new injuries or skin impairment to not be identified and addressed by staff.

Sources: Resident's clinical health records, the home's Skin Care Program Overview policy #LTC-CA-WQ-200-08-01 revised in December 2017, CIS; Interviews with Agency Registered Practical Nurse (RPN), and Assistant Director of Care (ADOC). [653]