Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 2, 2023	
Inspection Number: 2023-1340-0005	
Inspection Type: Critical Incident	
Licensee: Villa Forum	
Long Term Care Home and City: Villa Forum, Mississauga	
Lead Inspector Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2023.12.05 09:24:11 -05'00'
Additional Inspector(s) Patrishya Allis (000762)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 19, 20, 23, 24, 25, 2023

The following intake(s) were inspected:

- Intake: #00019477 - Critical Incident(CI) # 2855-000005-23 related to Falls Prevention and Management.
- Intake: #00021385 - Critical Incident(CI) #2855-000009-23 Prevention of Abuse and Neglect.
- Intake: #00022913 - Critical Incident(CI) #2855-000012-23 Prevention of Abuse and Neglect.
- Intake: #00097560 - Critical Incident(CI) #2855-000028-23 - Falls Prevention and Management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary
Resident was not toileted with two person extensive assistance as specified in the plan.

On March 10, 2023 resident was toileted by one person assistance. Interviews with a Personal Care Provider (PCP), a Registered Practical Nurse(RPN) and the Director of Care (DOC) confirmed that plan of care for toileting was not followed.

Not following the plan of care puts the residents at risk of harm.

Sources: Resident's Care Plan, home's investigation notes and interviews with PCP, RPN and DOC. [741104]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident is protected from abuse and are not neglected by the licensee or staff.

Rationale and Summary
On March 10, 2023 at approximately 1230-0146 hours during night shift, Resident reported that they were roughly handled. As per the elder abuse assessment form resident reported that the call bell was taken away from them, then placed back within their reach afterwards.

Interview with Registered Practical Nurse (RPN) confirmed that the staff was abrupt with the resident and the call bells were not responded to.

Director of Care (DOC) confirmed that resident was emotionally upset at that time of the incident and the resident said that the Personal Care Provider (PCP) was abrupt, rough and was not polite at the time of the incident.

Resident's needs were unmet, when call bells was taken away and resident was emotionally upset as staff was abrupt with her.

Sources: Resident's progress notes, Home's investigation notes, Elder abuse assessment form, interviews with RPN and DOC.
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