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
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Original Public Report

Report Issue Date: March 5, 2024	
Inspection Number: 2024-1340-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Villa Forum	
Long Term Care Home and City: Villa Forum, Mississauga	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 31, 2024 and February 1, 2, 5, 6, 7, 2024

The following intake(s) were inspected:

- Intake: #00102585 - [CI: 2855-000032-23] - Covid-19 - Outbreak.
- Intake: #00106508 - Complaint with concerns regarding lack of skin and wound care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary
A) A Resident was admitted to the hospital and returned to the home with wound care orders. The Plan of care was updated with interventions to improve the resident's skin integrity and to promote the wound healing. On February 2nd, 2024, during a review of the care plan and Kardex in a home area for a resident, the last update for the care plan was onJuly 30th, 2023.
Inspector # 741441 confirmed with a staff if the Care plan was current, and she stated that it had not been updated in the binder, but the Point Click Care (PCC) is current. The staff confirmed the current date of review for the care plan as which by logging into the PCC.

During an interview with the DOC, they acknowledged that the Kardex and Care plan on the unit was not up to date with the current Plan of care.

The home's failure to ensure that staff have the correct plan of care can cause inconsistency in the care received by the resident.

Rationale and Summary
B) The current Plan of care required the resident to be turned and repositioned to help promote wound healing. The intervention was on the care plan but was not captured on the current POC Kardex.

During an interview with the DOC, they acknowledged that the Kardex on the POC did not reflect the current care plan.

The home's failure to follow to update the plan of care could have put the resident at skin breakdown.

Sources: Incident report, POC record, Resident's Plan of care, interview with DOC. [741771]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if

clinically indicated;

The Licensee has failed to ensure that a resident was reassessed at least weekly by a member of the registered nursing staff when the resident exhibited an altered skin integrity.

Rationale and Summary
A registered staff documented their assessment of a resident's wound. However, the wound was not reassessed or treated. There was no documentation on the wound and the resident was admitted to the hospital two weeks later.

During an interview with the ADOC, they acknowledged that a weekly follow up should have been completed when the skin alteration was discovered on the resident.

Failure to ensure the resident's wound was assessed could have put the resident at risk for infection.

Sources: Incident report, POC record, interview with DOC, Resident's plan of care. [741771]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 3. Monitoring of all residents during meals.

The licensee has failed to ensure that residents were monitored during meals.

Rationale and Summary
On January 31, 2024, during a meal service observation in a dining room, there was no registered staff present or near the dinning room. Residents were served their meal and there was no presence of a registered staff.
On two other units, the residents were eating and there was no registered staff present in the dining room.
The next day, in a dining room, there was no registered staff present and some residents were drinking fluids. Soup service began, and residents started to eat.

During an interview with the DOC, they acknowledged that registered staff should be in the dinning room at the start of the meal service till the end when resident's have finished eating, to ensure that residents receive the right texture of food and observe the resident's swallowing and eating in the event of an undesired event and for there to be a pleasurable meal service.

Failure to ensure the residents are monitored during the meal service, places the resident at risk for aspiration and reduced intake.

Sources: Observations, interview with staff and the DOC. [741771]