



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
 Performance Improvement and Compliance Branch
 Division de la responsabilisation et de la performance du système de santé
 Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
 119 King Street West, 11th Floor
 HAMILTON, ON, L8P-4Y7
 Telephone: (905) 546-8294
 Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
 119, rue King Ouest, 11^{ème} étage
 HAMILTON, ON, L8P-4Y7
 Téléphone: (905) 546-8294
 Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 24, 25, Feb 7, 2012	2012_060127_0002	Critical Incident

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

RICHARD HAYDEN (127)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the administrator and co-directors of care regarding H-002071-11.

During the course of the inspection, the inspector(s) reviewed management's investigation file of the incident, a resident's plan of care, policies and procedures, and an employee's personnel file.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

<p>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.)</p>	<p>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.)</p>
<p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On January 24, 2012, the inspector confirmed the following: The licensee failed to ensure the care set out in an identified resident's plan of care was provided to him/her as specified in the plan. In 2011, a staff member did not ensure the resident's safety when he/she left him/her alone while he/she was being toileted. The resident attempted to get off the toilet without assistance and was found on the floor by staff. The resident did not sustain any injury as a result of the fall.

The resident's plan of care that was current at the time of the incident indicated he/she required extensive assistance for the entire toileting process, transferring on/off toilet and that staff were to ensure his/her safety.

Management's documentation included a signed letter from staff describing the incident. They were trained in 2011 on proper transfer techniques and subsequently retrained.

Issued on this 16th day of February, 2012

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

