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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 8, 2024
Original Report Issue Date: June 14, 2024
Inspection Number: 2024-1340-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Villa Forum
Long Term Care Home and City: Villa Forum, Mississauga

Amended By Lillian Akapong (741771)	**Inspector who Amended Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2024.08.09 13:58:28 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: change the legislative reference O.Reg 246/22 in Compliance order 001 from section 2 to section 7.

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Lead Inspector Lillian Akapong (741771)	**Additional Inspector(s)** Kerry O'Connor (000769)
Amended By Lillian Akapong (741771)	**Inspector who Amended Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2024.08.09 13:57:21 -04'00'

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This report has been amended to: This report has been amended to: change the legislative reference O.Reg 246/22 in Compliance order 001 from section 2 to section 7.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17, 18, 19, 22, 23, 24, 25, 26, 30, 2024 and May 1, 2, 3, 2024.

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The following intake(s) were inspected:

- Intake: #00109026 - [CI] 2855-000002-24 - Fall of resident.
- Intake: #00110907 - Complaint with concerns regarding resident passing away.
- Intake: #00111368 - [CI] 2855-000005-24 - Injury of unknown cause for resident.
- Intake: #00112090 - [CI] 2855-000008-24 - Outbreak declared.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED 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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of

care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised at least every six months and when the resident's care needs changed.

Rationale and Summary
A) During a record review, a resident's transfer status on their kardex did not match the care plan. The kardex stated one assist while the careplan stated 2 assist for transfers. The plan of care did not clearly reflect the resident's transfer status to staff.

During an interview with one staff, they stated that the resident is a one person transfer and that should be in the plan of care and acknowledged that resident's plan of care was not updated when the resident's care needs changed.

Not updating the plan of care can put the resident at risk of injury.

Sources: resident progress note, observation, plan of care, and interviews with staff. [741771]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the plan of care set out clear directions to staff when a resident's condition had changed.

Rationale and Summary
One day, a resident had a change in condition. The staff called the POA (power of attorney) and provided an update. Directions were provided by the POA for staff to transfer the resident to hospital if they were in distress, or if their condition worsens. Two days later, the resident declined, progress notes reported that the resident had significant changes in their health status and the resident was not transferred to the hospital.

In an interview, one staff reported that when new orders regarding care directions are provided a customized task is created so that it populates in the MAR (medication administration record) to advise staff. The MAR was reviewed for ten days, there was no documentation of care directions provided by the POA. They reported when a resident is declining a multidisciplinary conference, including the physician, would take place with the family and POA. The level of care would be reviewed and changed if required. The DOC acknowledged a decline in the resident's condition during the 10 days reviewed. No care conference was held to discuss the resident's level of care.

Failure to ensure that the plan of care set out clear directions to staff who were providing direct care to the resident, contributed to the resident not being transferred to hospital when their health status changed.

Sources Progress notes for resident, MAR/TAR for January 2024, 24-hour report. Interviews with DOC and staff, Care plan for resident. [000769]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
A) As per the resident's plan of care, the resident should have staff present when walking. One day, the resident had a fall while ambulating alone in the hall. The resident's progress note identified that the resident was alone when they fell.

During an interview with one staff, they acknowledged that resident was walking alone when they fell and the care plan was not followed at the time the resident fell.

Not following the resident's plan of care put the resident at risk for falls.

Sources: resident progress note, observation, plan of care, and interviews with staff. [741771]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the care set out in the plan of care for a resident was based on an assessment of the resident.

Rationale and Summary
As per O.Reg. 246/ 22, s. 11 (1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.
The home's Falls policy titled Resident safety and Risk Management, indicates that for a fall score of 12 and higher visual interventions should be in place. A resident had a fall risk score higher than 12. During a review of the resident's care plan, there were no record of falls intervention in relation to the interventions identified in the policy. No visual identifiers were in place in the plan of care or visibly in the resident's room and on their assistive devices. The home's policy was not complied with as interventions were not in place for the resident.

During an interview with the DOC, they stated that for residents with a falls risk of 12 and above they should have visual identifiers in place. They acknowledged that falls interventions for high falls risk were not in place for the resident, falls risk level was not updated in the plan of care to reflect resident's falls needs required prior to fall and has not been updated post fall.

Not having the falls intervention in place puts the resident at a risk for falls.

Sources: resident progress note, observation, plan of care, and interviews with staff, Policy - Resident safety and Risk Management # LTC-CA-WQ-200-07-08 [741771]

WRITTEN NOTIFICATION: Skin and wound

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident received a skin assessment by a registered staff when they returned from the hospital.

Rationale and Summary
A resident returned from the hospital with a lesion one night and no skin assessment was documented in PCC.

During an interview with one staff, they acknowledged that a skin assessment was

not completed when the resident returned from the hospital.

Sources: observations in resident room, Skin and wound Policy and interviews with staff. [741771]

WRITTEN NOTIFICATION: Infection Prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the director with respect to the IPAC Standard was Implemented.

Rationale and Summary
During an observation on a unit, there were expired disinfectant wipes canister stored on the vital sign monitor cart and in the dining room for use by the staff.

The Environmental Manager and the IPAC lead acknowledged that the disinfected wipes in the dining room and on the Vitals sign cart were expired and actively in use by the home.

Failure to have ensured that the disinfectant wipes were used in accordance with the Minister's Directives, posed as a risk for infectious agents being disinfected effectively.

Sources: observations, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022) and interviews with staff. [741771]

COMPLIANCE ORDER CO #001 Duty to protect

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit and implement a plan to ensure that when a resident's health condition changes, the level of care is addressed at that time with the resident, SDM (substitute decision maker) and or the POA (power of attorney), and any directions related to care are documented and staff are aware of changes.

The plan shall include but is not limited to:
The creation of a process for registered staff to ensure when a resident's condition changes, staff know the care actions to follow as provided by the resident, SDM or POA.
The process should specify where changes to the level of care and new directions for care actions are documented in the plan of care.
The process should include a method for how staff recognize a change has occurred from the resident's baseline condition.
A process for checking in with the resident, SDM or POA regarding the plan and

update regarding resident status.

The compliance plan should provide education for registered staff on what information to obtain regarding new care directions when a resident's condition changes so that the plan is clear to the resident, POA and staff.

Please submit the written plan for achieving compliance for inspection #2024-1340-0002 to Lillian Akapong (741771), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by July 12, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that a resident was protected from neglect/abuse when at the time the resident had trouble breathing and elevated respirations, staff did not call the doctor on call.
Section 7 of Ontario Regulation (O. Reg.) 246/22 defines “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
When residents are admitted to the home, a communication of prior expressed wishes is reviewed and signed by the resident or POA. The form indicates that regardless of what is documented, when a resident has a change in condition, staff are obliged to speak with resident or POA for further care directions. This process was confirmed by DOC and staff during interviews.

A resident had a change in condition. A staff noted a significant change. Directions

were provided to the staff by the POA to transfer to hospital if condition worsens. On two separate dates, progress notes by staff advised of significant changes, noting a further decline. The resident was not transferred to hospital, their POA was not advised of further decline.

One day, the resident was seen urgently by the Nurse practitioner (NP). They noted in the progress notes decreased air entry and crackles in lungs. Orders were written by NP for a specific medication. The medication was received later that day, progress notes indicated resident responding but lethargic, refused to eat. The resident was not given new ordered medications until the next day.

Later on that day, progress notes indicated the resident had a progression in their decline. The physician was not called, the resident was not transferred to hospital, the POA was not advised of this change in status.

Some days later, the resident's condition worsened. A progress note by a staff, noted that the Primary care provider (PCP), advised them the resident was having difficulty breathing. The oxygen saturations were lower than the ordered range. The staff, did not call the physician, they did not advise the POA of this change in condition.

On another day over several hours, registered staff noted resident condition worsening over multiple progress notes throughout the day that respirations were increasing, and the resident was having trouble breathing. Staff did not call the physician or transfer the resident to the hospital, the POA was not advised of this decline.

On that same day staff noted the resident's the resident was becoming more lethargic, and their extremities were bluish and called the physician and resident's

POA were called. Staff did not call the physician for over three hours when the resident had trouble breathing, elevated respirations, and decreased oxygen saturations. They did not transfer the resident to the hospital when there was a change as directed by the POA.The resident was then transferred to hospital from the home, they passed away on the next day.

In an interview with the DOC, they acknowledged that changes had occurred in the residents' condition for one week and the increased respirations, indicated a worsening condition and the resident should have been transferred to hospital.

Failure of the licensee to ensure the resident was transferred to the hospital when they declined, caused a delay in treatment that may have jeopardized their health, safety or well-being, and may have contributed to the harm of the resident.

Sources Progress notes for resident, Care plan for resident. Interviews with staff and DOC. [000769]

This order must be complied with by July 12, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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