

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

Public Report

Report Issue Date: May 28, 2025

Inspection Number: 2025-1340-0002

Inspection Type:

Complaint

Licensee: Villa Forum

Long Term Care Home and City: Villa Forum, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 20, 22-23, 26-28, 2025

The following intake(s) were inspected:

- Intake: #00145183 - Complaint - Prevention of Abuse and Neglect, Housekeeping, Laundry and Maintenance Services, Skin and Wound, Prevention and Management, Food, Nutrition and Hydration
- Intake: #00146414 - Complaint - Prevention of Abuse and Neglect

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect

INSPECTION RESULTS

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

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

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 provide for strategies to reduce or mitigate falls when a resident was left unattended while their bed was not in the lowest position.

Later on, the resident's bed was adjusted to implement the plan of care. There was no harm or impact to the resident at the time when this non-compliance was remedied.

Sources: interviews with staff, resident clinical records, observations of resident room.

Date Remedy Implemented: May 26, 2025

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,

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

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

The licensee has failed to ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to a resident, specific to the frequency and timing of continence care.

Sources: Interviews with staff, resident's clinical records.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (ii)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(e) a weight monitoring system to measure and record with respect to each resident,

(ii) body mass index and height upon admission and annually thereafter.

The licensee failed to ensure compliance with the system for measuring and recording residents' height upon admission and annually thereafter.

This failure to consistently monitor the resident's height may have resulted in an inaccurate estimation of their Body Mass Index (BMI).

Sources: Resident's clinical records, Weights and Heights Policy Revision Approval date: July 2024 and Interview with the staff.