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: September 4, 2025
Inspection Number: 2025-1340-0004
Inspection Type:
Critical Incident
Follow up

Licensee: Villa Forum
Long Term Care Home and City: Villa Forum, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27, 28, 29, 2025 and September 2, 3, 4, 2025.

The following intake(s) were inspected:
-Intake: #00151568 - Follow-up #: 1 - 2025-1340-0003- CO #001, O. Reg. 246/22 - s. 51- certification of nurses. Compliance due date (CDD): August 15, 2025.
-Intake: #00153417 - Critical incident (CI) 2855-000014-25 - related to food, nutrition and hydration.
-Intake: #00153421 - CI 2855-000016-25 - related to resident care and support services.
-Intake: #00154086 - CI 2855-000018-25 - related to infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1340-0003 related to O. Reg. 246/22, s. 51

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards

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)
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 related to toileting needs.

Sources: Review of resident's plan of care, investigation notes, critical incident (CI); interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used equipment during care of a resident in accordance with manufacturers' instructions for an ARJO Carendo shower chair (2025).

Sources: Review of home's investigation notes and ARJO manufacturer's instructions for Carendo shower chair (2025), interview with DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control

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

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Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to ensure that the home's written plan for responding to infectious disease outbreaks for a respiratory outbreak was followed when the home did not contact Public Health when two residents had the same symptoms within 48 hours.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the written plan for responding to infectious diseases was complied with. Specifically, the home did not comply with the home's Outbreak Management Policy, which stated that Public Health would be notified when two or more residents presented with symptoms within 48 hours, and that notification was to occur when identified including evenings and weekends.

Sources: Outbreak Management Policy, emails between Public Health and the home, Line Listing related to the outbreak; and interview with the IPAC Lead.