Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 5, 2014	2014_306510_0018	H-000625-14	Critical Incident System

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

IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 10, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Co Director of Care, Registered Nurse and Registered Practical Nurse

During the course of the inspection, the inspector(s) observed the provision of care and services on the identified home area and reviewed relevant documents.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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:

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. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6(7)
Resident #1 was identified with extremely fragile skin. On an identified date, the resident sustained 4 skin tears during the provision of personal care by a personal care provider (PCP) at the home.
The care plan included a focus for skin integrity and clearly directed that care would be provided by two staff for toileting and dressing. The Co-Director of Care (CDOC) confirmed that toileting included changing incontinent products as defined by Minimum Data Set (MDS), and that dressing included undressing. The registered practical nurse (RPN) confirmed that the requirement for two staff in the care plan was clear in the kardex. The RPN reported that because the PCP had not worked on that particular home area for a while, they reviewed the kardex with the PCP prior to the PCP beginning care delivery. As well the PCP was reminded to work in pairs because many residents required two care providers. The RPN stated she encouraged the PCP to work with their partner.
Internal investigation notes reported that two PCP's transferred Resident #1 to bed after supper on the identified date. Both PCP's left the resident in bed to provide care for another resident. When this was complete, one PCP returned alone to Resident #1 where documentation stated they proceeded to provide evening care which included toiletting and undressing Resident #1. This was done by one PCP in the absence of their partner. As the PCP completed evening care, the PCP noticed bleeding from three skin tears on the left leg. The RPN was summoned and found 3 skin tears on the left leg and one skin tear on the left forearm.
Care was not provided to resident #1 as specified in their plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

Issued on this 15th day of August, 2014

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