Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
Oct. 22, 25, 26, 27, 2010	2010_169_2855_27Oct101629	Log #H-01112 Log #H-01251 Log # H-00904

Licensee/Titulaire

Villa Forum
175 Forum Drive
Mississauga L4Z 4E5
Tel 905 501 1443 Fax 905 501 0094

Long-Term Care Home/Foyer de soins de longue durée

Villa Forum
175 Forum Drive
Mississauga L4Z 4E5
Tel 905 501 1443 Fax 905 501 0094

Name of Inspector(s)/Nom de l'inspecteur(s)

Yvonne Walton

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection related to transferring of residents.

During the course of the inspection, the inspector spoke with: nursing staff, Assistant Director of Care, Acting Administrator, residents.

During the course of the inspection, the inspector observed care, observed transfer equipment, interviewed residents, interviewed staff, reviewed the clinical record of 5 residents.

The following Inspection Protocols were used in part or in whole during this inspection: Falls Prevention and Management Protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[2] WN
[2] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s.6(7)

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.

Findings:

1. Three residents were transferred back to bed by one Personal Support Worker instead of two and with the mechanical lift.

2. An identified **resident required a device while sitting in their chair, however this was not provided.**

2. An identified resident did not receive a device on their bed as part of their fall prevention plan.

Inspector ID #:	169

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 that ensures resident's receive care according to their plan of care. This plan is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s. 36.

36 Every licensee of a long-term care home shall ensure that staff uses safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. Three residents were transferred back to bed in an unsafe manner. They were to be transferred using the mechanical lift and this was not done.

2. An identified resident was observed self transferring into bed and the personal support worker did not intervene to provide the assistance as per the plan of care.

Inspector ID #:	169

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 that ensures resident's are transferred using safe methods, according to their plan of care . Also residents will be provided with all safety equipment, according to their plan of care.. This plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).