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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 29, 2023
Inspection Number: 2023-1340-0003
Inspection Type: Complaint Critical Incident System
Licensee: Villa Forum
Long Term Care Home and City: Villa Forum, Mississauga

Lead Inspector	**Inspector Digital Signature**
Romela Villaspir (653)	Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.03.29 16:46:47 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following dates:
March 15, 21-24, 2023, and off-site on March 27, 2023.

The following intakes were completed in this Complaint and Critical Incident (CI) inspection:

- Intake #00018867 was related to resident care and support services, nutrition and hydration, plan of care, recreational and social activities, and restorative care.
- Intake #00018068 was related to an injury from unknown cause.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Recreational and Social Activities

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 (1) (a)

The licensee has failed to ensure that a resident's written plan of care sets out the planned care for the resident, as it related to an intervention.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint related to an intervention not implemented by staff for a resident, during meal service.

The Assistant Director of Care (ADOC) indicated that staff were required to implement an intervention for the resident during meal service, to promote their ability to drink fluids on their own. The ADOC believed this intervention was initiated in the middle of 2022. The ADOC confirmed that the intervention was not in the plan of care for the resident.

During observations of three different meal services, staff did not implement the said intervention.

Three Personal Support Workers (PSWs) were unaware that the planned care for the resident was to implement this intervention, to allow them to independently drink their fluids.

By not setting out the planned care for the resident in their written plan of care, staff were not consistently implementing the intervention during meal service.

Sources: Resident's clinical health records; Inspector #653's observations; Interviews with the PSWs, and ADOC. [653]