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

Hamilton District
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Original Public Report

Report Issue Date: September 5, 2024	
Inspection Number: 2024-1340-0003	
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 19-22, 26, 27, 2024

The following intake(s) were inspected:

- Intake: #00116558 - Critical Incident (CI) related to Improper/Incompetent treatment of a resident by staff
- Intake: #00118789 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) Duty to Protect, Compliance Due Date July 12, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1340-0002 related to FLTCA, 2021, s. 24 (1) inspected by Michelle Warrener (107)

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

Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

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 their plan related to level of assistance required for care.

Rationale and Summary:
The plan of care for a resident included two staff for assistance when providing care

and when transferring the resident.

A Personal Support Worker (PSW) provided care to the resident without using another staff for assistance and the resident sustained an injury.

When staff did not provide the required level of assistance when caring for the resident, it resulted in injury to the resident.

Sources: interview with a PSW; clinical health record for a resident, including progress notes, assessments, and plan of care; the home's investigation notes; Critical Incident report.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the plan of care for a resident was revised when the resident's care needs changed related to fall risk.

Rationale and Summary:
An annual Scott Falls Risk Assessment was completed for a resident and reflected the resident was at high risk for falls. Prior to the annual risk assessment, the plan of

care identified a low risk for falls. A Registered Nurse (RN), who completed the assessment, stated that if there was a change in the risk score, registered staff were to update the care plan. The RN confirmed that the care plan had not been updated to reflect the change in fall risk score.

A Personal Support Worker (PSW) stated that PSWs obtain information about resident care needs from the care plan or kardex.

The resident had a fall with injury. During interview, two PSWs who cared for the resident stated the resident was not at risk for falling at the time of the fall and were not aware of the change in risk level after the assessment.

When the care plan was not updated to reflect the increased risk for falling, not all staff were aware of the increased risk.

Sources: interview with PSWs, and RN; the clinical health record for a resident, including progress notes, care plan, Scott Falls Risk Assessments.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report to the Director when there were reasonable grounds to suspect that there was improper or incompetent treatment or care of a resident that resulted in harm to the resident.

Rationale and Summary:
A Personal Support Worker (PSW) provided improper care to a resident, resulting in injury to the resident.

A Registered Nurse (RN), who was working at the time of the incident, stated they were informed of the improper care with resultant injury, however, they were not aware of the specific reporting process and the incident was not reported to the Director until the next day.

Sources: interview with PSW and RN; clinical health record for a resident, including progress notes, assessments, and plan of care; the home's investigation notes; the home's policy, LTC-CA-WQ-100-05-18 "Abuse Free Communities – Prevention, Education, and Analysis", revised March 2022; policy, LTC-CA-WQ-100-05-04 Reporting certain matters, revised September 2023; Critical incident report.