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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Public Report

Report Issue Date: July 3, 2025
Inspection Number: 2025-1156-0003
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Streetsville Community, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 27, 30, 2025 and July 2, 2025

The following intake(s) were inspected:

- Intake: #00145089 - 2648-000007-25 - fall prevention and management.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the fall prevention plan of care.

The nursing and maintenance departments did not collaborate with each other to ensure that a fall prevention strategy was implemented as per the resident's plan of care. The strategy was not in place three days after an assessment identified it was required, and the resident had a fall with injury.

Sources: clinical health record for a resident; interview with staff; maintenance records.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 for fall prevention and management.

The resident's plan of care included a fall prevention strategy. Staff confirmed the strategy was not in place when the resident was observed by the inspector. The resident had a history of a falls.

Sources: clinical health record for a resident; interview with staff; observations of the resident.