

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: August 22, 2025

Inspection Number: 2025-1156-0004

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): August 19-22, 2025

The following intake(s) were inspected:

- Intake: #00153622 - Critical Incident (CI) 2648-000008-25 - related to falls prevention and management.

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

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that

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the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

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 a resident's plan of care was provided as specified in the plan.

The MLTC inspector observed a falls management intervention in the resident's room, however the plan of care indicated that this intervention was no longer appropriate for the resident. The intervention was immediately removed by staff on the same day and all other falls interventions were in place at this time.

Sources: observation of the resident and their room; the resident's clinical records; and interview with staff.

Date Remedy Implemented: August 20, 2025