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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 29, 2025

Inspection Number: 2025-1007-0001

Inspection Type:
Critical Incident

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Cheltenham Community, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 21-24, 27, and 29, 2025
The inspection occurred offsite on the following date: January 28, 2025

The following intake was inspected:
-Intake: #00131980 with Critical Incident (CI)# 0922-000065-24 - was related to a fall resulting in injury.

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

Infection Prevention and Control
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 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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out their planned care regarding use of a positioning device.

The resident's plan of care did not include interventions related to a positioning device. Staff were using the positioning device for resident care. The Director of Care (DOC) acknowledged that the plan of care did not reflect the resident's planned care and care needs.

On January 27, 2025, the care plan was updated to include the positioning device.

Sources: Observations of resident, resident's care record, interviews with a Personal Support Worker (PSW), Registered Practical Nurse (RPN) and DOC.

Date Remedy Implemented: January 27, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on

an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the assistive device use set out in a resident's plan of care was based on an assessment of the resident.

The resident's plan of care directed staff to use an assistive device in a specific way. The assessment of the resident gave directions for a different method of using the assistive device. The nurse and DOC confirmed that the care plan was not based on the assessment.

On January 27, 2025, the resident's plan of care for use of the assistive device was updated to reflect the resident's assessment.

Sources: Observation resident's bedroom, resident's care record, interview with a RPN and DOC.

Date Remedy Implemented: January 27, 2025

WRITTEN NOTIFICATION: Plan of care

NC #003 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 license has failed to ensure that a resident's plan of care was revised when their care needs changed.

The resident was assessed by a physiotherapist and the resident's functional abilities had changed, requiring changes to the resident's care. The resident's plan of care was not updated and it included interventions that the nurses confirmed were on hold. The DOC acknowledged that the plan of care had not been updated when the resident's care needs changed.

Sources: Resident clinical record, interview with nurses and DOC.

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