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: March 10, 2025

Inspection Number: 2025-1007-0002

Inspection Type:
Complaint
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 date(s): February 24 - 28, 2025 March 3 - 7, 2025 and March 10, 2025.

The following intake(s) were inspected:
• Intake: #00139256 Critical Incident (CI): #0922-000008-25 was related to communicable disease outbreak.
• Intakes: #00137345 and #00139590 CIs: #0922-000005-25 and #0922-000009-25 were related to abuse of residents.
• Intake: #00138095 CI: #0922-000007-25 was related to fall of a resident resulting in injury.
• Intakes: #00131500 and #00131510 CIs: #0922-000061-24 and #0922-000063-24 were related to allegations of abuse and improper care.
• Intakes: #00132354 and #00137228 CIs: #0922-000066-24 and #0922-000004-25 were related to resident to resident altercations with injury.

The following intakes were completed in this critical incident inspection:
• Intakes: #00133797 and #00136308 CI: #0922-000070-24 and #0922-000003-25 were related to fall of residents resulting in injury.
• Intakes: #00133726 and #00139256, #00139910, #00136086 and CI: #0922-

000069-24, #0922-000008-25, #0922-000010-25, #0922-000001-25 were related to communicable disease outbreaks.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 there was a written plan of care for the use of a specific safety device for a resident. A resident was observed with a specific safety device that was not included in their plan of care.

A Registered Practical Nurse (RPN) immediately updated the care plan to include the safety device.

Sources: Observation; a resident's clinical records; policy titled Falls Prevention & Management; and interview with a nurse.

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Date Remedy Implemented: February 28, 2025

WRITTEN NOTIFICATION: Policy To Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed ensure that the written policy to promote zero staff tolerance of abuse and neglect of residents was complied with. Specifically, the licensee has failed to assess a resident, document assessments and inform the Executive Director / designate of the home of a abuse incident as per the home's policy.

Sources: A resident's clinical records; policy titled Prevention of Abuse & Neglect of a Resident; interview with a nurse and Director Of Care (DOC).

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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) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

(i) Specifically, Specifically, when two staff witnessed the abuse of a resident, the home failed to immediately report the incident to the Director.

Sources: A resident's clinical records; policy titled Prevention of Abuse & Neglect of a Resident; interviews with a nurse and the DOC.

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(ii) When a nurse was informed of the suspected abuse of a resident, the home failed to immediately report the incident to the Director.

Sources: A resident's clinical record; investigation notes; and interview with the Assistant Director Of Care (ADOC).

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WRITTEN NOTIFICATION: 24-Hour Admission Care Plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 27 (3) (b)
24-hour admission care plan
s. 27 (3) The licensee shall ensure that the care plan sets out,
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 246/22, s. 27 (3).

The licensee has failed to ensure that the care plan set out clear directions for transfers to staff and others who provided direct care to a resident. A resident's care plan did not provide clear directions on the type and level of assistance required for staff to provide transfer assistance.

Sources: A resident's clinical records; investigation notes; interviews with a Personal Support Worker (PSW), a nurse, the ADOC and the Physiotherapist (PT).

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WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents.

Resident's plan of care included an intervention to prevent altercation with other residents.

A PSW did not follow the directions in the care plan, which led to an altercation. Behavioural Supports Ontario (BSO) Nurse acknowledged
that the PSW should have followed the directions as indicated in the resident's care plan

Source: Residents clinical records; interview with a PSW and the BSO.

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