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: July 31, 2025

Inspection Number: 2025-1007-0006

Inspection Type:
Critical Incident
Follow up

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): July 22, 24 - 25, 28 - 31, 2025.

The following intakes were inspected during Critical Incident (CI) inspection:
- Intake: #00143142 / CI #0922-000014-25 was related to fall of a resident.
- Intake: #00150587 / CI #0922-000022-25 was related to medication management.

The following intake was inspected during follow-up inspection:
- Intake: #00149261 was follow-up related to previously issued compliance order under Ontario Regulation 246/22, s. 24 (1) - air temperatures.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2025-1007-0003 related to O. Reg. 246/22, s. 24 (1)

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

Medication Management
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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 assessment of the resident's injury, so that their assessments were integrated and were consistent with and complemented each other.

A Resident had a fall, which resulted in an injury. The resident had never visited hospital for follow-up as recommended at the time of discharge, and was also never assessed for healing status of the injury.

Sources: Review of resident's electronic and physical chart, interviews with Registered Practical Nurse (RPN), Physiotherapist (PT), Registered Nurse (RN) and Assistant Director Of Care (ADOC).

WRITTEN NOTIFICATION: Plan of Care

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 the use of a specific intervention to manage an injury was provided to a resident, as specified in the plan.

On two occasions on an identified date, the resident was observed not using the specific intervention.

Source: Observations, interviews with RPN, PT, RN and ADOC.

COMPLIANCE ORDER CO #001 Medication Management System

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and

disposal of all drugs used in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

1. Provide education to all registered staff and nursing management on the home's COVID-19 Resident Immunization Program policy, Vaccine Storage and Handling Guidelines policy, and vaccine clinic administration process.
2. Keep a written record of the education provided including, but not limited to, the person providing the education, date of education provided, the education content provided, and sign in sheets of attendance.

Grounds

(a). The licensee has failed to ensure they complied with written policies and protocols that were developed for the medication management system to ensure resident vaccination process were implemented.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee is required to ensure that written policies and protocols developed for the medication management system were complied with. Specifically, staff did not comply with the "COVID-19 Resident Immunization Program" policy, which outlines a systematic step by step process for onsite resident vaccination.

Multiple residents received expired shelf life vaccine. The staff in the home did not follow the vaccine immunization process to ensure the following:

-An Infection Prevention and Control (IPAC) Lead was present during the administration to oversee and provide directions to registered staff.

-A pre-arranged designated date for the vaccine clinic was communicated to the staff.
-Correct vaccines were received in the home and administered to residents.
-Expired shelf life vaccines were removed from the refrigerator.

The IPAC Lead, IPAC Partner, and RN acknowledged that the staff did not follow the vaccine clinic administration process for the vaccination of residents.

Sources: Critical Incident System (CIS) report, home's investigation file, home's policy "COVID-19 Resident Immunization Program, IX-D-10.12" last reviewed July 2025, home's process "Preparing for Resident onsite Vaccine Clinic Checklist", and interviews with IPAC Lead, IPAC Partner, RN and other staff.

(b). The licensee has failed to ensure they complied with written policies and protocols that were developed for the medication management system to ensure expired vaccines were removed from the storage area.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee is required to ensure that written policies and protocols developed for the medication management system were complied with. Specifically, staff did not comply with the policy "Vaccine Refrigerator Temperature Monitoring", to remove/dispose of vaccines that were expired.

The IPAC Lead conduct an audit of the vaccine refrigerator and identified 17 boxes of vaccines which were not in use. The vaccines were removed from the vaccine fridge. The IPAC Lead and IPAC partner acknowledged that the unused vaccines should have been removed from the fridge and returned to public health.

The shelf life of the vaccines to be used was 10 weeks after receiving them from local public health unit, after which vaccines were to be removed/disposed. After

nearly six months of receiving the vaccines, multiple residents received expired shelf life vaccine as they were left in the fridge and not identified for removal.

Sources: Critical Incident System (CIS) report, homes investigation file, home's policy "Vaccine Refrigerator Temperature Monitoring, IX-D-20.10" last reviewed May 2025, and interviews with IPAC Lead, IPAC Partner, RN and other staff.

This order must be complied with by September 5, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.