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
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Public Report

Report Issue Date: November 3, 2025
Inspection Number: 2025-1007-0008
Inspection Type:
Complaint
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): October 24, 27 -30, 2025 and November 3, 2025

The following Follow up intakes were inspected:
- Intake: #00154249 -Follow-up related to Medication Management
- Intake: #00154724 -Follow-up related to Certification of Nurses

The following Complaint intakes were inspected:
- Intake: #00160475 -Complaint related to Resident Care and Support Services

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1007-0006 related to O. Reg. 246/22, s. 123 (2)
Order #001 from Inspection #2025-1007-0007 related to O. Reg. 246/22, s. 51

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

Resident Care and Support Services
Medication Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to be afforded privacy in caring for their personal needs was fully respected and promoted.

A Personal Support Worker (PSW) transported a resident down the hallway to the shower room and did not maintain privacy during the transport. The Director of Care (DOC) acknowledged that the PSW failed to protect the resident's right to privacy.

Sources: Review of the resident's clinical records, video footage records and interviews with the DOC and other staff.

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

The resident's plan of care indicated they required a specific level of assistance for transferring, however this was not provided to the resident. The DOC acknowledged that the transfer intervention was not provided as specified in the resident's plan of care.

Sources: Review of the resident's clinical records, video footage records and interviews with the DOC and Executive Director (ED).

WRITTEN NOTIFICATION: Staff Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 2.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which they are a member, or verification of the staff member's current registration with the regulatory body governing their profession.

The licensee has failed to ensure that a record was kept for Registered Practical Nurse (RPN), that included a verification of the staff member's current certificate of registration with the College of Nurses of Ontario (CNO).

Review of human resource file for two RPNs revealed that the licensee did not maintain proof of verification of registration with the CNO.

Sources: Review of the RPNs human resource file, interviews with the ED, DOC and Team Member Experience Coordinator.