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

Ottawa District
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Public Report

Report Issue Date: October 2, 2025
Inspection Number: 2025-1240-0003
Inspection Type: Critical Incident
Licensee: Genesis Gardens Inc.
Long Term Care Home and City: Foyer St-Viateur Nursing Home, Limoges

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1, 2, 2025

The following Critical incident (CI) intake was inspected:

- Intake: #00156616/CI #2746-000001-25 related to a resident fall with injury

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

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 (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 the written plan of care for a resident outlined the required use of a specialized device.
A review of the resident's plan of care indicated the usage of another assistive device.
During an interview, the Assistant Director of Care (ADOC) acknowledged and confirmed that the resident's written plan of care did not include specific instructions and usage of the specialized device and that it should have been documented.

Sources: Resident's plan of care, staff and ADOC interviews.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's therapeutic intervention order was supported by a written plan of care with specific and clear treatment instructions.
During a review of the resident's plan of care, there was no documentation for the ordered therapeutic intervention.

The Assitant Director of Care (ADOC) acknowledged and confirmed that there was no written plan of care for the resident's order.

Sources: Resident's plan of care and progress notes, observations, ADOC interview.