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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: June 4, 2025

Inspection Number: 2025-1137-0003

Inspection Type:
Critical Incident

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

Long Term Care Home and City: Secord Trails Community, Ingersoll

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27, 28, 29, 2025 and June 2, 3, 4, 2025

The following intake(s) were inspected:

- Intake: #00145832 - Critical Incident System (CIS) #2628-000007-25 concerning alleged staff to resident physical abuse
- Intake: #00146081 - CIS #2628-000008-25 concerning a resident fall with injury
- Intake: #00146791 - CIS #2628-000012-25 concerning a resident fall with injury

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

Prevention of Abuse and Neglect
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 (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

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised related to a resident's assistive aid.

The Inspector noted through observations, the resident positioned in an assistive aid and a record review of the resident's care plan had not indicated use of an assistive aid.

During an interview with the Assistant Director of Care (ADOC), they advised that the assistive aid had not been documented in the care plan. They further advised that on this day, they revised the care plan to include the use of the assistive aid.

Sources: review of a CIS report, the home's policy "Documentation-Plan of Care", a resident's care plan and progress notes, observations of the resident, staff interviews with ADOC and the Director of Care (DOC).

Date Remedy Implemented: May 28, 2025

WRITTEN NOTIFICATION: Care Plan

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 concerning all aspects of personal care.

A Critical Incident System (CIS) report was received by the Director which indicated that a resident was not provided care during a particular shift.

A review of the resident's care plan and Kardex indicated that the resident required assistance with all aspects of personal care.

During an interview with the DOC, they advised that the Personal Support Worker (PSW) failed to provide the resident with personal care during the entire shift and failed to provide care to the resident, as per their care plan.

Sources: review of a CIS report, the home's policy "Documentation – Plan of Care", investigation notes, employee file for a PSW, a resident's electronic records and a staff interview with the DOC.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented, concerning all aspects of personal care.

A Critical Incident System (CIS) report was received by the Director which indicated that a resident was not provided care during a particular shift.

A review of Point of Care (POC) documentation by a PSW on that shift, indicated that their care needs had been provided.

The DOC stated that the PSW had not provided any personal care for the resident, and they had documented personal care as being given.

Sources: review of a CIS report, the home's policy "Documentation – Plan of Care", investigation notes, employee file for a PSW, a resident's electronic records and a staff interview with the DOC.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 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 to ensure that a Registered Nurse (RN) complied with the home's policy for zero tolerance of abuse and neglect of residents regarding the immediate reporting of alleged abuse concerning a resident.

A Critical Incident System (CIS) report was received by the Director concerning alleged physical abuse toward a resident by a Personal Support Worker (PSW).

The alleged incident was reported by an RN a few days later.

The Director of Care (DOC) advised that the RN failed to immediately report a suspicion of abuse concerning a resident and they failed to follow the homes Abuse policy.

Sources: review of a CIS report, the home's policy "Prevention of Abuse and Neglect", investigation notes, an employee file for a PSW, a resident's electronic records and a staff interview with the DOC.