

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****Long-Term Care Operations Division  
Long-Term Care Inspections Branch****Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**Toronto Service Area Office  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 15, 2020	2020_642698_0018	010349-20, 018438- 20, 022418-20	Complaint

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**Licensee/Titulaire de permis**Vigour Limited Partnership on behalf of Vigour General Partner Inc.  
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8**Long-Term Care Home/Foyer de soins de longue durée**Cheltenham Care Community  
5935 Bathurst Street North York ON M2R 1Y8**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

ORALDEEN BROWN (698)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): November 12, 13, 17-20, 23 and 24, 2020.**

**The following intakes were completed during the course of this complaint inspection:**

**Log #018438-20 was related to alleged abuse and neglect.**

**Log #010349-20 was related to multiple care areas.**

**Log #022418-20 was related to nutrition.**

**During the course of the inspection, the inspector observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other documents.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Environmental Services (DES), Director of Programs and Services (DPS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Team, residents and family.**

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

**Accommodation Services - Housekeeping**

**Accommodation Services - Maintenance**

**Contenance Care and Bowel Management**

**Dignity, Choice and Privacy**

**Dining Observation**

**Infection Prevention and Control**

**Nutrition and Hydration**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)  
0 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service****Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**  
**9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents #004 and #005 were provided with assistive devices required to safely eat and drink as comfortably and independently as possible.

During an onsite inspection during a lunch service, resident #004 and #005 were observed eating their meals in their rooms without a tray table. Resident #004's meal tray was left on their night table where they had to stand and eat their meal while resident #005's meal tray was left uncovered on a foot stool at their bedside.

Review of resident #004's care plan indicated that they required supervision during meals and resident #005's care plan indicated that they required extensive assistance by one staff.

Interview with a PSW indicated that they delivered a meal tray to resident #005 and placed their meal tray on the foot stool at the side of their bed with the intentions of returning to assist the resident with their meal. Interview with a second PSW indicated that they delivered tray service for resident #004 and did not provide them with a tray table to eat their meal. Interview with RN #108 indicated the unit was supplied with enough tray tables for residents eating in their rooms during isolation.

Sources: resident observations, electronic records, interviews with ED and other staff. [s. 73. (1) 9.]

**Issued on this 15th day of December, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**