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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: November 8, 2024
Original Report Issue Date: September 11, 2024
Inspection Number: 2024-1012-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Glen Rouge Community, Scarborough

AMENDED INSPECTION SUMMARY

This report has been amended to:

- Rescinded Compliance Order #001 Complaint Procedure - Licensee - Non-compliance with: FLTCA, 2021, s. 26 (1) (c).
- Rescinded Compliance Order #002 Reporting certain matters to Director Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8 & 9, 12 - 16, 19 - 22, 2024

The following intake(s) were inspected:

- A complaint related to plan of care.
- Two intakes related to outbreaks.
- A complaint related to alleged abuse.

- An intake related to a fire.
- An Intake related to a fall of a resident.
- An intake related to resident care.
- An intake related to the improper care of a resident.
- An intake related to allege emotional abuse of resident.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director an allegation of improper care of a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to an allegation of improper care of resident. A verbal complaint was also made to the Long Term Care Home (LTCH) in relation to the allegation.

The CIR indicated the home received a complaint alleging improper care of resident. The home submitted a CIR to the Director one day late. The DOC confirmed that the CIR should have been submitted immediately.

There was no risk to the resident as a result of the late report.

Sources: CIR, interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Licensee failed to ensure their Infection Prevention and Control (IPAC) program, a program under, O. Reg. s. 102 was complied with, specifically related to the LTCH's policy that states the IPAC Lead or Designate to maintain all records related to any outbreak including daily outbreak line listing, outbreak management team minutes and completed checklists.

Rationale and Summary

A CIR was submitted to the Director and indicated an infectious disease outbreak at the LTCH.

The Inspector noted that during the inspection the outbreak documentation was incomplete, including the required IPAC self-assessment checklist.

The Executive Director (ED) confirmed that the IPAC Lead during the outbreak had not maintained records as required by the LTCH's policy for the outbreak.

Failure to maintain records and documentation related to the outbreak, the outbreak management team was unable to complete a full assessment, to mitigate further outbreaks and reduce the risk of exposure to infectious diseases for residents and staff.

Sources: CIR, Confirming an Outbreak Policy, Interview with the ED.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023, specifically, at a minimum Routine Practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact, under Routine Practices and Additional Precautions 9.1, under the IPAC standard.

Summary and Rationale

The LTCH's Hand Hygiene policy states that all team members and volunteers will practice hand hygiene to reduce the spread of infection.

During observations in the home, the inspector noted a staff member assisting with snack service on a resident home area. They were observed entering one room to feed a resident and performed no hand hygiene prior to or after feeding the resident. They then took a a drink to another room to another resident without performing hand hygiene prior to, and after assisting the resident, and then preceded to further assist other residents with snacks.

The Infection Prevention and Control (IPAC) Lead stated that all staff and visitors are to comply and follow the four moments of hand hygiene and confirmed that the staff member did not follow the moments.

With the staff member not following the four moments of hand hygiene, put the residents and staff at risk for exposure to infectious diseases.

Sources: Observations, Hand Hygiene Policy and interview with IPAC lead.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a verbal complaint was made to the licensee concerning the care of a resident, a response was provided within 10 business days of the receipt of the complaint.

Rationale and Summary

A CIR was submitted to the Director by the LTCH related to an allegation of improper care of a resident. The LTCH received a verbal complaint alleging improper care of the same resident. As a result of the allegation the home immediately initiated an investigation.

During a review of the home's complaint records, there was no indication that a response was provided to the complainant. The ED and the DOC informed the inspector on separate interviews that a response was provided 28 business days after receipt of the complaint.

The home's Complaints Management Program policy stated the home was required to provide a response to the complainant within 10 business days of the receipt of the complaint.

Failure to provide a response to the complainant within 10 business days of the receipt of the complaint resulted in lack of transparency in the complaint management process.

Sources: The home's complaints records, Complaints Management Program policy and interviews with the DOC and the ED.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the

action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record is kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary

A CIR was submitted to the Director related to an allegation of improper care of a resident. The LTCH received a verbal complaint alleging improper care of the same resident. As a result of the allegation the home immediately initiated an investigation.

A review of the home's complaint records revealed no documentation of the action taken had been completed by the home. The DOC informed the inspector that the investigation revealed improper care was not founded, but that the home had identified an opportunity to improve communication between the nurses and the complainant. The DOC verified that the home was required to document the actions taken upon completing an investigation into a complaint.

There was no impact or risk sustained to the resident as a result of the missing documentation of the actions taken.

Sources: Complaint form, interview with the DOC.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record is kept in the home that included the date on which the response was provided to the complainant and a description of the response.

Rationale and Summary

A CIR was submitted to the Director related to an allegation of improper care of a resident. The LTCH received a verbal complaint alleging improper care of the same resident. As a result of the allegation the home immediately initiated an investigation.

A review of the home's complaint records indicated that there was no documentation of the date on which the response was provided to the complainant and a description of the response. The DOC and the ED confirmed that the ED provided the complainant with a response on a specific date. The DOC and the ED verified that the home was required to document the date on which the response was provided to the complainant and a description of the response upon completing an investigation into a complaint.

There was no impact or risk sustained to the resident as a result of the non compliance.

Sources: Complaint form, interview with the DOC and the ED.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

1) The licensee failed to report to the Director immediately a infectious disease outbreak at the home.

Summary and Rationale

A Critical Incident Report (CIR) was submitted to the director on related to the reporting of a a infectious disease outbreak in the home..

An outbreak confirmation letter received by the home from Toronto Public Health (TPH) confirmed that the outbreak started on a specific date. ED of the home confirmed that any outbreaks are to be reported immediately to the Director and that the outbreak was reported two days after it was confirmed by TPH.

There was no risk to residents related to the outbreak.

Sources: CIR, TPH Outbreak Confirmation Letter, and interview with ED.

2) The licensee failed to report to the Director immediately an infectious disease outbreak at the home.

Summary and Rationale

A CIR was reported to the Director related to an infectious disease outbreak in the home.

An outbreak confirmation letter received by the home from TPH confirmed that the outbreak started on a specified date. The ED of the home confirmed that any outbreaks are to be reported immediately to the Director and that the outbreak was reported two days after it was confirmed by TPH.

There was no risk to residents related to the outbreak.

Sources: CIR, TPH Outbreak Confirmation Letter, and interview with the ED.

WRITTEN NOTIFICATION: CMOH and MOH

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The Licensee failed to ensure that all applicable directives, orders, guidance, advice

or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024, section D. Contact Management, directs the IPAC Lead/ Designate to conduct weekly IPAC audits for the duration of the outbreak.

Summary and Rationale

A CIR was submitted to the Director related to an infectious disease outbreak at the LTC Home.

The Inspector received weekly IPAC Audit for the first and second week of the outbreak but did not receive the third week's IPAC audit.

The IPAC Lead and the ED affirmed that this was to be completed weekly during an outbreak. The ED confirmed that the IPAC Audit was not completed during the third week of the outbreak.

As IPAC Audits are to look for opportunities identify weaknesses and to manage an outbreak of infectious diseases, this put residents and staff at risk for exposure.

Sources: CIR, Weekly IPAC Self Assessment Audits and interviews with IPAC Lead and ED.

(A1)

The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Complaints procedure — licensee

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

(A1)

The following order(s) has been rescinded: CO #002

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

COMPLIANCE ORDER CO #003 Hazardous substances

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

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

Grounds

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Summary and Rationale

During a tour of the home, it was observed, that multiple housekeepers' carts on were found unlocked in the units and left unattended with hazardous chemicals in the cart accessible to residents in the home.

A Housekeeper stated that the carts are to be locked or place in the housekeeper's closet. The Director of Environmental Services (DES) confirmed that the housekeepers cart contained hazardous chemicals for cleaning and that they are to be locked up when left unattended or kept in the locked in the housekeepers closet when not in use. The DES also stated there was a risk to residents with exposure or ingestion of the chemicals.

There was a risk of harm to residents with access to the hazardous cleaning chemicals as they could have been exposed or been ingested.

Sources: Observations, photographs, interviews with Housekeeper and Director of Environmental Services.

This order must be complied with by December 5, 2024.

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

Grounds

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023, specifically, The licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and that a

summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices, under Outbreak Preparedness and Management 4.3, under the IPAC standard.

Rationale and Summary

A CIR was submitted to the Director related to an infectious disease outbreak at the LTC Home.

Upon reviewing the outbreak documentation, the LTC home could not provide the inspector with proof that following the resolution of the outbreak that a debrief session with the homes Outbreak Management Team (OMT) and IPAC team was conducted and findings for recommendations for the home for improvements to outbreak management practices.

The IPAC Lead stated that after an outbreak a post outbreak debrief session is to occur and be documented. The ED confirmed that this did not occur after this outbreak.

As the home did not complete the debrief session to identify IPAC practices that were effective and ineffective, and to create recommendations for improvements for outbreak management, this increased the risk to residents and staff exposure to infectious diseases.

Sources: CIR, LTCH's Outbreak Documentation, interviews with IPAC Lead and ED.

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023, specifically, The licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and that a summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices, under Outbreak Preparedness and Management 4.3, under the IPAC standard.

Rationale and Summary

A CIR was submitted to the Director related to an infectious disease outbreak at the LTC Home.

Upon reviewing the outbreak documentation, the LTC home could not provide the inspector with proof that following the resolution of the outbreak that a debrief session with the homes Outbreak Management Team (OMT) and IPAC team was conducted and findings for recommendations for the home for improvements to outbreak management practices.

The IPAC Lead stated that after an outbreak a post outbreak debrief session is to occur and be documented. The ED confirmed that this did not occur after this outbreak.

As the home did not complete the debrief session to identify IPAC practices that were effective and ineffective, and to create recommendations for improvements for outbreak management, this increased the risk to residents and staff exposure to infectious diseases.

Sources: CIR, LTCH's Outbreak Documentation, interviews with IPAC Lead and ED.

This order must be complied with by December 5, 2024

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

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
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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.