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

# Public Report

**Report Issue Date:** April 3, 2025

**Inspection Number:** 2025-1012-0001

**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

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 24, 25, 26, 27, 28, 31, 2025 and April 1, 2, 3, 2025

The following intake(s) were inspected:

- A complaint regarding care and communication.
- A complaint related to rest routines and responsive behaviour.
- Critical Incident Report (CIR) related to resident to resident verbal abuse.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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.

The Licensee failed to ensure that a person who has reasonable grounds to suspect abuse of resident's by a resident that resulted in harm or a risk of harm to multiple resident's was reported immediately to the director.

A CIR was submitted to the Director where a resident had an altercation with another resident after they accidentally physically contacted another co-resident. Another resident began verbally abusing the initial resident. The incident was not submitted to the Director three days after the abuse occured.

During a review of a resident's medical records, a further three incidents of abuse were found but were not reported to the director. The first incident was witnessed abuse by a resident to another resident. The second incident occured when a resident was seen abusing another resident. The third incident occured when a resident abused a resident after an interaction with another co-resident.

**Sources:** CIR, resident's medical records, interviews with Behaviour Supports Ontario (BSO) lead and Associate Director of Care (ADOC) #108.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)**
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The Licensee failed to ensure that matters related to responsive behaviour program, in subsection (1) were implemented for a resident.

A complaint was received to the Ministry of Long Term Care (LTC) from a complainant related to the reduced and interrupted sleep of a resident due to co-resident's responsive behaviours. This was affecting the resident. The co-resident was referred to the BSO Lead for behavioral assessment and follow up to assist in determining the cause of their responsive behaviour. A Behavioural Supports Ontario – Dementia Observation System (BSO-DOS) was to be initiated but was not found by the LTC home. There was no documentation found related to assessing the co-residents behaviours by the BSO Lead, No new interventions were identified or implemented for co-resident.

**Sources:** Complainant, resident's medical records, interview with ADOC #109 and Executive Director (ED).

## COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

**Grounds**

The Licensee failed to protect multiple resident's from abuse by another resident.

According to Ontario Regulation 246/22, the definition of verbal abuse is any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

Three CIR's were sent to the Director related to the abusive behaviours of the resident to other co-residents.

The resident was initially transferred to hospital and returned to the LTC home, without implementing any further interventions to keep other residents safe.

Upon returning to the LTC home the BSO Lead initiated a BSO-DOS assessment the resident but did not implement any other interventions to keep other residents safe.

**Sources:** CIR's, resident's medical records and interviews with BSO Lead and ADOC

#108.

**This order must be complied with by** June 12, 2025

## COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 59 (b)**
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

**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 steps were taken to minimize the risk of altercations between a resident and potentially harmful interactions towards multiple co-resident's by identifying and implementing interventions.

Three CIR's were sent to the Director related to the abusive behaviours of the resident to other co-residents.

The resident was initially transferred to hospital and returned to the LTC home, without implementing any further interventions to keep other residents safe.

Upon returning to the LTC home the BSO Lead initiated a BSO-DOS assessment on the resident but no other interventions were implemented to minimize the risk of altercations between other residents.

**Sources:** CIR's, resident's medical records and interviews with BSO Lead and ADOC #108.

**This order must be complied with by** June 12, 2025

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## 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.