

**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:** May 13, 2025

**Inspection Number:** 2025-1012-0002

**Inspection Type:**

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): May 5-9, and 12-13, 2025.

The following intake(s) were inspected:

- Intake related to a respiratory outbreak.
- Intake related to resident to resident alleged abuse.

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

Infection Prevention and Control  
Responsive Behaviours  
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection prevention and control program

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

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**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that multiple residents signs and symptoms of infection were recorded on every shift. The Long-Term Care Home's policy indicated it was to be recorded in the residents health record. A Registered Nurse and The Infection Prevention and Control (IPAC) Lead confirmed that this information was to be recorded in the Progress notes. The IPAC Lead indicated the symptoms were not recorded.

**Sources:** Progress notes; Interviews with RN and IPAC Lead ; Signs & Symptoms of Infection Policy

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**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

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