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: June 26, 2025

Inspection Number: 2025-1012-0003

Inspection Type:
Complaint
Follow up

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): June 18, - 26, 2025.

The following intake(s) were inspected:

- Follow-up # 1 - Compliance Order #004 issued to O. Reg. 246/22 - s. 59 (b) Altercations and other interactions between residents- CDD June 12, 2025.
- Follow-up # 1 - COMPLIANCE ORDER #003- issued to FLTCA, 2021 - s. 24 (1). Duty to protect- CDD June 12, 2025
- Complainant related to improper care of resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1012-0001 related to O. Reg. 246/22, s. 59 (b)
Order #001 from Inspection #2025-1012-0001 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
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,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations;

Steps were not taken to minimize the risk of potentially harmful interactions, including identifying contributing factors based on staff observations. Clinical records indicated that a resident received new pharmacological interventions on several occasions to help manage responsive behaviours.

However, the Dementia Observation System (DOS) was not initiated during these instances. On dates when the DOS was initiated to monitor responsive behaviours, it was not completed in its entirety, and there was no documented analysis or evaluation of the data collected.

According to staff, a DOS should have been initiated with each pharmacological intervention. Staff also indicated that the DOS should have been completed and that a documented analysis should have been available.

Sources: Resident clinical record, the home's policy titled Responsive Behaviours Management, and an interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed of an incident that caused an injury to a resident, resulting in hospitalization and a significant change in condition.

The resident experienced a witnessed fall that led to injury requiring hospitalization and surgical intervention, as well as two unwitnessed falls with injuries that required hospital treatment, interdisciplinary assessment, and changes to the plan of care.
Sources: resident clinical records and interviews with staff.

WRITTEN NOTIFICATION: Medication incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

A resident was admitted to the home in February 2024. Medication reconciliation completed at the time of admission indicated a prescription with the right dose of the medication. However, the resident was administered half the dose for a period of time.

The resident experienced a fall that required hospitalization. The medication error was identified during the hospital stay and was documented in the medication reconciliation notes in PCC upon the resident's return to the home.

Although staff were aware of the error, there is no documentation of a critical incident report, its analysis, or any reporting of the incident to the Director of Nursing, the prescriber, the pharmacy service provider, or the attending physician.

Sources: Resident clinical records, and interview with staff.

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