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

Toronto District
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Public Report

Report Issue Date: December 18, 2024
Inspection Number: 2024-1052-0005
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Rockcliffe Community, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 16-18, 2024

The following intake(s) were inspected:

- Intake: #00128768 / Critical Incident (CI) #2131-000017-24 was related to the outbreak of a communicable disease
- Intake: #00132460 / CI #2131-000021-24 was related to the fall of a resident resulting in injury

The following intakes were completed in this inspection:

- Intake: #00127800 / CI #2131-000016-24 and Intake: #00129021 / CI #2131-000018-24 were related to outbreaks of communicable disease

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in a resident's plan of care was based on an assessment completed for the resident. Specifically, resident's plan of care did not indicate the correct assessed falls risk level.

Sources: Review of resident's clinical records and Interview with Registered Nurse (RN).

Date Remedy Implemented: December 17, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's fall prevention intervention was in place as specified in their plan of care. The resident was observed without fall prevention intervention in place and Personal Support Worker (PSW) verified that the resident should have had the fall prevention intervention in place as specified in their plan of care.

Sources: Observation of a resident, review of resident's plan of care, and interview with PSW.