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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 15, 2025
Original Report Issue Date: June 17, 2025
Inspection Number: 2025-1052-0003 (A1)
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Rockcliffe Community, Scarborough

AMENDED INSPECTION SUMMARY

This report has been amended to:
Written Notification NC #004 was rescinded.

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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report (A1)

Amended Report Issue Date: July 15, 2025
Original Report Issue Date: June 17, 2025
Inspection Number: 2025-1052-0003 (A1)
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Rockcliffe Community, Scarborough

AMENDED INSPECTION SUMMARY

This report has been amended to:
Written Notification NC #004 was rescinded.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 9-13, 16, 17, 2025

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00142285 – [CIS: 2131-000004-25] – Communicable disease outbreak
- Intake: #00142709 – [CIS: 2131-000005-25] – Communicable disease outbreak
- Intake: #00145247 – [CIS: 2131-000006-25] – Resident to resident abuse
- Intake: #00146273 – [CIS: 2131-000008-25] – Missing resident
- Intake: #00146382 – [CIS: 2131-000009-25] – Unexpected death
- Intake: #00147735 – [CIS: 2131-000012-25] – Communicable disease outbreak
- Intake: #00148604 – [CIS: 2131-000013-25] – Communicable disease outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that resident #003 was protected from physical abuse by resident #004.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Resident #004 and resident #003 were involved in an altercation, resulting in an injury to resident #003.

Sources: Resident #003’s clinical notes; and interviews with Personal Support Worker (PSW) and the Director of Care (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 has failed to ensure the implementation of a standard issued by the Director with respect to Infection Prevention and Control (IPAC). The home has failed to ensure proper use of personal protective equipment (PPE), including appropriate application of PPE in accordance with the IPAC Standard as required by Additional Precaution 9.1 (f) under the Standard.

A PSW was observed entering a resident's room, who was on droplet/contact precautions. The PSW wore a gown, gloves, and face shield, however applied a second surgical mask over their existing surgical mask. The PSW confirmed that they did not wear the surgical mask appropriately.

Sources: Observations; IPAC Standard for Long-Term Care Homes, revised September 2023; and interview with PSW.

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 (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 has failed to ensure that multiple residents' symptoms were recorded on each shift when they were demonstrating signs of infection.

Multiple residents' symptoms were not documented on different shifts when they were on droplet/contact precautions.

Sources: Multiple residents' progress notes and daily resident status assessments; and interview with IPAC Lead.

(A1)
The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: CMOH and MOH

NC #004 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.