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
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Public Report

Report Issue Date: December 16, 2024

Inspection Number: 2024-1012-0003

Inspection Type:
Complaint
Critical Incident
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): December 10-13, 16, 2024

The following intake(s) were inspected:

- Intake related to a complaint regarding improper resident care
- Intake related to a resident injury of unknown cause
- First Follow-up- CO #003/2024-1012-0002, related to O. Reg. 246/22 - s. 97, Hazardous Substances, with compliance due date (CDD) of December 5, 2024.
- First Follow-up - CO #004/2024-1012-0002, related to O. Reg. 246/22 - s. 102 (2) (b), IPAC Program, with CDD of December 5, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #004 from Inspection #2024-1012-0002 related to O. Reg. 246/22, s. 102 (2) (b)

Order #003 from Inspection #2024-1012-0002 related to O. Reg. 246/22, s. 97

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INTEGRATION OF ASSESSMENTS, CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure the home's staff, Physician and Substitute Decision Maker (SDM) of a resident were involved and collaborated with each other when the resident's health status started to decline. Two registered staff assessed the resident after a medical event in which the resident's status changed and they were started on a new treatment.

The Physician and SDM were not informed of the change in status of the resident and the new treatment initiated. Another staff also indicated they noted a change in the resident's status at the start of their shift however did not inform the registered staff.

Sources: Home's investigation notes, resident clinical records, interviews with staff.

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's resident-staff communication and response system equipment was accessible to the resident at all times. On a specific date a resident required assistance from nursing staff however could not access the staff via their communication system. A registered staff confirmed when they assessed the resident, the communication system was not accessible for the resident to use.

Sources: Home's investigation notes, interview with staff.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident received weekly skin and wound assessments related to an area of altered skin integrity. A review of the resident's clinical records identified an initial skin and wound assessment being completed, another one a few weeks later and a final assessment months later when the area had healed. A registered staff member confirmed the weekly skin and wound assessments had not been completed weekly for the resident's area of altered skin integrity.

Sources: Resident's clinical records and interview with staff.