

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: October 7, 2025
Inspection Number: 2025-1012-0005
Inspection Type: Complaint 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): September 23 to 29, 2025 and October 1, 2, and 7, 2025

The following intake(s) were inspected:

- A complaint related to the dietary department.
- An intake related to an altercation between two residents.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

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1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee failed to ensure that there were written approaches to care, including the identification of behavioural triggers that may result in responsive behaviours. Staff identified a trigger for a resident which had led to an altercation. Staff indicated that the care plan should have included this identified trigger.

Source: Clinical records for residents, Interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

3. Resident monitoring and internal reporting protocols.

The licensee failed to ensure that resident monitoring and internal reporting protocols were followed for a resident when their Dementia Observation System (DOS) was not completed in its entirety. Staff indicated that the DOS must be completed in its entirety in order to analyze and create meaningful interventions. They further indicated that the staff are informed to complete the DOS during shift to shift report, however they could not identify why the DOS was incomplete.

Sources: Clinical records for residents, interviews with staff.

WRITTEN NOTIFICATION: Menu planning

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NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (5)

Menu planning

s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that planned menu items were offered and available at breakfast, when bananas were unavailable. Staff indicated that there were no banana's available for the residents at breakfast.

Sources: The home's policy, Menu Substitution Log, Production sheets and Invoices, Observations, and Interviews with staff.

WRITTEN NOTIFICATION: Food production

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (2) (e)

Food production

s. 78 (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that have similar nutritional value;

The licensee failed to ensure that menu substitutions have similar nutritional value; when the home did not provide a substitution for bananas. Staff indicated that there were no bananas available, and no substitution was provided.

Sources: The home's policy, Menu Substitution Log, Production sheets and Invoices, Observations, and Interviews with staff.

WRITTEN NOTIFICATION: Food production

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

Food production

s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee failed to communicate to residents and staff of any menu substitutions when the posted menu did not indicate a substitution for bananas. Staff indicated that bananas were unavailable, and the posted menu did not reflect the shortage or any substitutions.

Sources: The home's policy, Menu substitution Log, Production sheets and Invoices, Observations, and Interviews with staff.

WRITTEN NOTIFICATION: Food production

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)

Food production

s. 78 (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

The licensee failed to document on the production sheet of any menu substitutions when there were no bananas available for breakfast. Staff indicated that the production sheets did not indicate that there were no bananas available, or any substitutions for which was offered to the residents.

Sources: The home's policy, Menu Substitution Log, Production sheets and Invoices, Observations, and Interviews with staff.



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

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