

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: November 17, 2025

Inspection Number: 2025-1012-0006

Inspection Type:
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): November 3-5, 7, 12- 13, 2025

The inspection occurred offsite on the following date(s): November 14, 17, 2025

The following intake(s) were inspected:
Intakes related to abuse.

Intake related to falls.

Intake related to improper care.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
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.

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NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

Resident's written plan of care and kardex did not provide clear direction to staff. Resident's written care plan and kardex was updated on November 5, 2025.

Sources: Resident's care plan and interview with Director of Care (DOC).

Date Remedy Implemented: November 5, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

Resident right to freedom from abuse was not protected.

An incident of abuse occurred when a resident, made verbal remarks towards another resident.

Sources: clinical records and interview with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 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 care set out in the plan of care was not provided to the resident, as specified in the plan.

Staff responded to the resident's fall and it was noted during assessment that the resident's plan of care in relation to falls was not followed.

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



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

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