

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: July 22, 2025

Inspection Number: 2025-1157-0006

Inspection Type:

Critical Incident
Follow up

Licensee: Tendercare Nursing Homes Limited

Long Term Care Home and City: Tendercare Living Centre, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9-11, 14-17, and 22, 2025.

The inspection occurred offsite on the following date(s): July 18 and 21, 2025.

The following intake(s) were inspected:

- An intake related to Follow-up #1 to Compliance Order (CO) #004, Inspection #2025-1157-0003, with Compliance Due Date (CDD) July 8, 2025.
- An intake related to Follow-up #1 to CO#003, Inspection #2025-1157-0003, with CDD July 8, 2025.
- An intake related to Follow-up #1 to CO#002, Inspection #2025-1157-0003, with CDD July 8, 2025.
- An intake related to Follow-up #1 to CO# 001, Inspection #2025-1157-0003, with CDD July 8, 2025.
- An intake related to an outbreak

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- An intake related to improper care of a resident
- Two intakes related to Falls prevention and management

Previously Issued Compliance Order(s)

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

Order #004 from Inspection #2025-1157-0003 related to O. Reg. 246/22, s. 356 (3)

Order #003 from Inspection #2025-1157-0003 related to O. Reg. 246/22, s. 78 (3) (b)

Order #002 from Inspection #2025-1157-0003 related to FLTCA, 2021, s. 19 (2) (c)

Order #001 from Inspection #2025-1157-0003 related to FLTCA, 2021, s. 5

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

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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.

A resident has had multiple falls in a short period of time, with one of the falls resulting in a significant injury needing surgical interventions.

During an observation, the resident was transferred from their mobility device to their bed, which was positioned at its lowest height.

The resident's plan of care indicated the bed should be at regular height, and to avoid low bed height, low chairs, and low toilet. There were transfer instructions posted above the resident's bed, indicating that the bed should be positioned at knee height as well.

Sources: Observations, the resident's care plan.

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

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