Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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

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

Original Public Report

Report Issue Date: September 14, 2023	
Inspection Number: 2023-1049-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Scarborough, Scarborough	
Lead Inspector Arther Chandramohan (000720)	**Inspector Digital Signature**
Additional Inspector(s) Slavica Vucko (210)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11, 2023
The inspection occurred offsite on the following date(s): August 14-15, 2023

The following intake(s) were inspected:

- Intake: #00092404: 2117-000007-23 - Critical Incident related to resident to resident abuse resulting in injury.
- Intake: #00092592: 2117-000008-23 - Critical Incident unexpected death of resident.
- Intake: #00092969: Complaint related to medication administration.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Admission, Absences and Discharge

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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)

Introduction:
The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #001.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary:
On an identified date, after an incident with resident #001, resident #002 was found by Personal Support Worker (PSW) #119. Resident #001 had a physical interaction with resident #002. Resident #002 subsequently sustained injuries from their physical altercation.

Progress notes from resident #001 and an interview with Registered Nurse (RN) #123 confirmed physical abuse had occurred. Activity Aide #118 translated from the residents involved that a physical confrontation had occurred.

There was physical impact to resident #002 when they were physically abused by resident #001.

Sources:
Interview with RN #123 and other staff, progress notes of resident #001, and plan of care.
[000720]