

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

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

Public Report

Report Issue Date: November 13, 2025

Inspection Number: 2025-1049-0006

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Scarborough, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4-7, 12, 2025

The following intakes were inspected on in this Critical Incident (CI) inspection:

- Intake: #00159842/ CI #2117-000054-25 - related to prevention of abuse and neglect
- Intake: #00160302/ CI #2117-000057-25 - related to injury of unknown cause

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

Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of 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;

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The licensee has failed to ensure staff involved in a resident's care collaborated with each other.

On a specified date, a staff member informed registered staff that a resident had a significant change. The registered staff failed to assess the resident and to endorse to the incoming shift that the resident had experienced a significant change. The lack of collaboration between staff delayed treatment to the resident.

Sources: A resident's clinical records, LTCH's investigation notes, interviews with staff members.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect that a resident had been abused, it was immediately reported to the director. The Director was not informed until the next day through the after-hours notification system.

Sources: A resident's clinical records, Ontario LTC Homes Portal and interview with staff

WRITTEN NOTIFICATION: Continence care and bowel management

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Continence care and bowel management

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s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable;

The licensee failed to ensure a resident was provided sufficient continence care product changes to remain dry, clean and comfortable. On a specified date, a resident informed a staff member that they required a continence product change, however did not receive a change until several hours later; which left the resident wet, soiled and uncomfortable.

Sources: A resident's clinical records, the home's investigation notes, and interview with staff



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

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