

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:** September 25, 2025

**Inspection Number:** 2025-1049-0005

**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): September 15-19, 23-25, 2025

The following intakes were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00153065 [CIS: 2117-000044-25] - related to resident-to-resident abuse
- Intake: #00155227 [CIS: 2117-000046-25] - related to an injury of unknown cause
- Intakes: #00155952 [CIS: 2117-000048-25] and #00157473 [CIS: 2117-000052-25] - related to disease outbreaks

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

- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

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

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**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; and

The licensee has failed to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other in an assessment for the resident as ordered by a physician. A Registered Nurse (RN) initiated a specific assessment for the resident during a shift. However, another RN did not continue the same assessment on the following shift.

**Sources:** A resident's clinical records; and Interviews with two RNs.

**WRITTEN NOTIFICATION: Plan of Care**

NC #002 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 licensee has failed to ensure that a resident's fall interventions equipment were applied. The resident experienced a change in health condition during care and a Personal Support Worker (PSW) assisted the resident to the floor. The resident was later diagnosed with an injury.

**Sources:** A resident's clinical records; Home's investigation notes; and interviews with a PSW.

**WRITTEN NOTIFICATION: Reporting Certain Matters to Director**

NC #003 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

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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 the suspicion of physical abuse between two residents was reported immediately to the Director. The home submitted a CIS report after normal business hours instead of reporting the incident using the Ministry's method for after hours emergency contact as per the reporting requirements.

**Sources:** CIS 2117-000044-25; Reporting Requirements for LTC Homes, October 2022, updated June 2023; and interview with an ADOC.

## WRITTEN NOTIFICATION: Falls Prevention and Management

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

**Non-compliance with: O. Reg. 246/22, s. 54 (2)**

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was conducted when a resident was assisted to the floor by a PSW which was considered a fall per the home's policy.

**Sources:** A resident's clinical records; Home's investigation notes; Interview with a PSW; and Home's policy titled "Falls Prevention and Management Program", RC-15-01-01, last reviewed June 2025.

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**

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Infection prevention and control program  
s. 102 (2) The licensee shall implement,  
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes issued by the Director was complied with.

A PSW failed to ensure that they wore PPE in accordance with the IPAC Standard 9.1 that Routine Practices and Additional Precautions are followed in the IPAC program. Specifically, the PSW did not wear gloves and a long-sleeved gown when entering a resident's room, who was on additional precautions, and providing direct care to the resident which is part of the home's procedure for properly applying PPE.

**Sources:** Observation; and interviews with a PSW and the IPAC lead; IPAC Standard for long Term Care Homes, revised September 2023, Additional Requirement 9.1, and IPAC Policy #IPC2-P10.03, Effective Date: February 18, 2025.

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

### Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a PSW participated in the implementation of the IPAC program.

A PSW was present in a resident's room, providing one-on-one care while the resident was on additional precautions. During this time, the PSW's mask was not properly worn, as it was not covering their nose.

**Sources:** Observation; Home's IPAC policy, Personal Protective Equipment (PPE)



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

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#IPC2-P10.10, effective date: February 18, 2025, interviews with a PSW and the IPAC lead.