Ontario

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

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 3, 2025

Inspection Number: 2025-1157-0008

Inspection Type:
Complaint
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): October 21-23, 27-29, 2025 and November 3, 2025
The inspection occurred offsite on the following date(s): October 30, 2025
The following intake(s) were inspected:

- a complaint related to food.
- Two critical incidences related to unwitnessed falls with injury.
- Follow-up intake #2: Compliance order (CO) #002, 2025-1157-0005, O. Reg. 246/22 - s. 79 (1) 4. Dining and snack service, CDD: September 4, 2025, RIF: $500.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1157-0005 related to O. Reg. 246/22, s. 79 (1) 4.

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

Food, Nutrition and Hydration
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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)
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from neglect by a Personal Support Worker (PSW).

A resident identified as a high risk fall due to their medical condition, experienced a fall when a PSW was providing care to the resident's roommate. The PSW did not respond to the resident's repeated calls for assistance, nor did they use the call bell to seek help, believing that other staff were busy and that they could manage the situation independently. As a result, the resident fell and was subsequently transferred to the hospital, with a significant change in their condition.

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

WRITTEN NOTIFICATION: Protection from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 3.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
3. Restrained by the use of a physical device, other than in accordance with section 35 or under the common law duty referred to in section 39.

The licensee failed to ensure that residents were not restrained due to the home's bed setup.

Observations revealed that several beds, including those of 4 residents were positioned with one side attached to a wall or window. A review of the care plans for these residents showed no assessment or consent related to this bed setup, which constitutes

a form of restraint. Interviews with two staff members confirmed that beds are often placed against walls. The Executive Director acknowledged awareness of the issue and agreed that it was considered a restraint. The Executive Director cited family preferences and cultural practices as contributing factors, but confirmed that the home has a zero-restraint policy and an active plan in place to address the issue.

Sources: Observations, multiple resident clinical records, and staff interviews.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The license failed to ensure that a residents falls prevention measures were in place.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee was required to ensure that the written policies developed for the falls prevention program were complied with. Specifically, the home's fall prevention and management program policy stated that the LTCH would promote the use of universal fall precautions, none of which were implemented for a resident.

A resident had an unwitnessed fall while left unattended in the room due to isolation. Staff reported that the resident did not have an identified intervention at the time of the incident although this intervention was included in the resident's plan of care as a fall prevention measure. Staff were also uncertain if other interventions which were directed in the care plan had been completed.

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

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Second follow-up

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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