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

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Public Report

Report Issue Date: December 5, 2025
Inspection Number: 2025-1157-0009
Inspection Type: Critical Incident
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): November 26-28, 2025 and December 1, 3-5, 2025
The inspection occurred offsite on the following date(s): December 2, 4, 2025

The following intake(s) were inspected:
-An intake related to a resident fall that resulted in injury
-An intake related to a resident fall that resulted in injury
-An intake related to neglect of residents
-An intake related to the improper care of a resident

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

A registered staff attempted to contact a resident's next of kin but when they were unable to connect, contacted a different type of contact listed for the resident and subsequently shared Personal Health Information (PHI) that the contact was not authorized to receive. A staff member indicated that they would share PHI with a Power of Attorney (POA) or next of kin but not usually share health information with other types of contacts. There was no documentation detailing permission to disclose PHI to this contact.

Sources: Health records for a resident and interviews with staff.

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.

Instructions were present in a resident's plan of care related to the use of an assistive device. The resident utilized the assistive device, however, the instructions for use were not followed as outlined in the plan, which was acknowledged by the staff.

Sources: Health records for a resident, the home’s video footage, and interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
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.

According to O. Reg. 246/22, s. 7. the definition of neglect is, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A resident was feeling unwell. Despite multiple staff and family reports, there was a significant delay before the nurse assessed them and transferred them to the hospital, during which no action was taken.

Sources: Health records for a resident, the home's investigative notes, and interview with a staff member.

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident’s desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

A written complaint from a resident's Substitute Decision Maker (SDM) reported that the resident's individualized rest routine was not supported. The care plan provided specific instructions related to their rest routine. The home's internal investigation, along with an interview with a staff member, confirmed that the instructions related to their rest routine were not followed.

Sources: Review of a resident's health records, the home's investigative notes, and interview with a staff member.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The home's Falls Prevention and Management Program, which outlines strategies to reduce or mitigate falls, did not provide for the reassessment of a resident's fall risk, following a fall they sustained.

The home's Fall Prevention and Injury Reduction Procedure outlined that after a fall, the nurse must review the resident's most current fall risk level. If the resident is not already identified as high risk, the nurse must complete the Integrated Fall Risk Assessment to determine any changes in the resident's risk level.

A staff member confirmed that an Integrated Falls Risk Assessment was completed for the resident on a specific date and further acknowledged that the resident's risk level was not reassessed following a fall.

Sources: Health records for a resident, the home's Fall Prevention and Injury Reduction Procedure, and interview with a staff member.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 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 home's Falls Prevention and Injury Reduction Policy outlined that resident safety and independence will be supported through the implementation of restorative care approaches, use of equipment, supplies, assistive devices, and referrals as appropriate.

Instructions were present in a resident's plan of care related to the implementation and

use of a fall prevention intervention. The resident was observed without the intervention in place. A staff member acknowledged that the resident did not have the intervention. Another staff member confirmed that the resident's plan of care contained instructions for the resident to have this intervention and acknowledged that it should be in place.

Sources: Observation, Health records for a resident, the home's Falls Prevention and Injury Reduction Policy, and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

A drug was discovered to have been administered to a resident. It was determined that the drug had originated from a staff member's personal possession and was administered to the resident without a prescription or order for the drug for the resident.

Sources: Health records for a resident, Medication Incident Report, and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned

to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (2), or
(B) is an internationally trained nurse who is working as a personal support worker. O. Reg. 66/23, s. 28 (1). Or

A Personal Support Worker (PSW) administered a drug to a resident. The PSW had not received training in the administration of drugs, did not have the appropriate skills, knowledge, and experience to administer drugs in a long-term care home and furthermore, was not assigned to perform the administration by a member of the registered nursing staff, nor was under the supervision of that member. The PSW confirmed that it is not within their role to administer medications to residents. The DOC also confirmed that the home does not have any PSWs administering medications.

Sources: Health records for a resident, Medication Incident Report, Home's Investigation Notes, and interviews with staff.