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

London District
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Public Report

Report Issue Date: February 19, 2026

Inspection Number: 2026-1175-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Port Stanley, Port Stanley

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11, 12, 13, 17, 18, 19, 2026

The following intake(s) were inspected:

- Intake: #00161353 - CIS # 2669-000004-25 related to Prevention of Abuse and Neglect.
- Intake: #00161952 - Follow-up #: 1 -related to Compliance Order #001 from inspection 2025-1175-0004 related to FLTCA, 2021 - s. 82 (2) with a compliance due date of December 19, 2025.
- Intake: #00164039 - CIS # 2669-000005-25 related to Falls Prevention and Management.
- Intake: #00164983 - CIS # 2669-000006-25 related to Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1175-0004 related to FLTCA, 2021, s. 82 (2)

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

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and 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)
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.

A resident was not protected from physical and verbal abuse by a staff member.

Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a

resident" and physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

An internal investigation by the home found that staff member verbally abused a resident when providing care and physically abused another resident.

Sources: Critical Incident System (CIS) #2669-000004-25, Internal Investigation Notes, and interviews with Operations Manager and other staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee did not comply with their policy titled "Incident Management: Interventions to Support Recipients of Alleged Abuse or Neglect" (Effective April 1, 2025), which falls within the home's Zero tolerance of Abuse Program.

When allegations of physical and verbal abuse were brought forward, there were no documented physical assessments and monitoring of the resident, as per the home's policy.

The Infection Prevention and Control (IPAC) Manager stated that the home was not in compliance with their Zero Tolerance of Abuse and Neglect program with

regards to following up on the allegations of verbal and physical abuse by staff towards the resident.

Sources: Clinical Records for resident, "Interventions to support recipients of alleged abuse or neglect Policy" (Effective April 1, 2025), and an interview with IPAC Manager.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The home received allegations of physical abuse of a resident by a staff, related to an incident that occurred in the home. An investigation of the incident was not completed by the home until a later date.

Sources: review of email communication, clinical records of resident, and interview with IPAC Lead.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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.

A) An allegation of verbal and physical abuse by a staff towards a resident was not reported to the Director until a later date.

Sources: Critical Incident System Report #2669-000004-25, Internal Investigation Notes, and an interview with Operations Manager.

B) An allegation of physical abuse by a staff member towards a resident reported to the home's management, was not reported to the Director until a later date.

Sources: Critical Incident System Report #2669-000006-25, Internal Investigation Notes, interview with staff.