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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: July 9, 2025

Inspection Number: 2025-1236-0004

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Telfer Place, Paris

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25, 26, 30, 2025 and July 3, 4, 7, 8, 9, 2025

The following intake(s) were inspected:

- Intake: #00148474 - Critical Incident System (CIS) report #2742-000016-25, related to allegations of staff to resident abuse.
- Intake: #00149770 - CIS #2742-000018-25, related to falls and resident care management.

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

Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
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:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure a resident's right to proper care consistent with their needs was promoted.

A record review for a resident and staff interviews showed the resident experienced an emergent incident and did not receive proper monitoring throughout the incident.

Sources: resident records, video surveillance review, staff interviews.

WRITTEN NOTIFICATION: Duty to protect

NC #002 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.

The licensee failed to ensure that multiple residents were protected from abuse by

a staff member, when the Director of Care (DOC) failed to act on multiple allegations of staff to resident abuse reported.

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

"Verbal abuse" means 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.

"Emotional abuse" mean any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of the home's investigation notes and staff interviews showed that over a period of time a number of resident abuse incidents occurred, involving a specific staff member, despite having been witnessed by multiple staff and the staff reporting the incidents to the DOC.

Interviews with staff and management supported that the DOC should have taken immediate action when staff first shared their concerns and that staff had a responsibility to intervene and continue to report to different parties to ensure the staff member was stopped, the residents were protected from abuse and the abuse was not allowed to continue.

Sources: Interviews with staff and management, the home's investigation notes and the home's Abuse and Whistleblower policies and procedures, review of

LTCHomes.net and CARES.

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 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 failed to ensure when there were reasonable grounds to suspect staff to resident abuse by a staff member, that the suspicions and the information upon which they were based were immediately reported to the Director. Reasonable grounds to suspect staff to resident abuse was provided when multiple staff members reported their concerns to the DOC. Furthermore, the staff that witnessed or had concerns about the staff member abusing residents did not report their suspicions to another member of the management team, the licensee, or the Ministry of Long-Term Care to ensure their responsibility to report was fulfilled.

Sources: Interviews with staff and management, review of the home's investigation notes and the home's Abuse and Whistleblower policies and procedures, review of LTCHomes.net and CARES.