Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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

Central East District
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Public Report

Report Issue Date: August 21, 2025
Inspection Number: 2025-1409-0006
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Port Hope, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 11-15 and 19-21, 2025.

The following intake(s) were inspected:

Intake related to a complaint regarding resident safety.
Intakes related to abuse.
Intake related to a medical emergency.

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect

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.

1.The licensee has failed to ensure that the resident was protected from verbal abuse by a visitor.

Verbal abuse is defined within Ontario Regulation (O. Reg.) 246/22, 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.

A Critical Incident (CI) was reported to the Director, which indicated that the resident, was subject to inappropriate verbal exchange by a visitor. As a result, the resident sought emotional support from staff.

During an interview with the personal support worker (PSW), who witnessed several incidents of this verbal exchange from the visitor, towards the resident, reported they were concerned for the resident's safety.

Sources: Review of CI; review of resident's progress notes; review of the home's internal investigation record; interview with staff.

2.The licensee has failed to ensure that the resident was protected from abuse by a visitors.

Verbal abuse is defined within Ontario Regulation (O. Reg.) 246/22, 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.

CI's were reported to the Director which indicated that the resident, was subjected to inappropriate verbal exchange by two visitors. Additionally, one visitor had continued access to the resident and on a subsequent visit, was overheard obtaining information. As a result, the resident continued to be upset and sought emotional support from staff.

During an interview with the PSW, who witnessed several incidents from the visitors, towards the resident, reported there was a safety concern for both the resident and staff.

Sources: Review of CI's; review of residents progress notes; review of the home's internal investigation record; interviews with staff.

3.The licensee failed to ensure that the resident was protected from verbal abuse.

In accordance with Ontario Regulation (O. Reg) 246/22, s. 2 (1) (a) 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.

Staff could hear inappropriate verbal exchange from the visitor to the resident, staff immediately informed the RN, who approached the resident's room and witnessed the incident. When the visitor noticed the RN was present, the visitor's demeanor changed. Police were notified of the incident and the visitor, was removed from the home. As a result, the resident sought emotional support from staff.

By failing to ensure that the resident was protected from verbal abuse by a visitor, the resident was at an increased risk of experiencing emotional distress.

Sources: Internal investigation notes, CI and interviews with RN and DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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.

1.The licensee failed to report an allegation of staff to resident abuse to the Director immediately.

A CI was reported to the Director indicating an allegation of visitor to resident verbal abuse toward the resident.

The home's investigation notes indicated that an incident of verbal abuse toward the resident occurred. The RN acknowledged that they did not report the incident to the Director immediately.

The home's ADOC confirmed the allegation of abuse toward resident should have been reported immediately to the Director.

Failure to immediately report allegations of resident abuse increases the risk of further harm to residents.

Sources: CI, the home's investigation notes and interviews with ADOC.

2.The licensee failed to report allegation's of abuse involving the resident to the Director immediately.

The Director received a complaint, indicating that email communication had occurred with the home's Executive Director (ED) in the past, where allegations of abuse were reported to the home which, were not reported to the Director.

Review of the contents of the email communication between the complainant and the home's ED was carried out, where allegations of abuse from the visitor towards the resident were communicated with the ED on multiple occasions. These incidents were not reported to the Director.

Failure to immediately report allegations of abuse of residents puts resident at increased risk of harm of further incidents.

Sources: Emails and interview with the complainant and Executive Director.