

**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: February 14, 2025

Inspection Number: 2025-1409-0002

Inspection Type:  
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): February 11, 12, 14, 2025  
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) was inspected:

- Intake: #00131318 - CI 2925-000037-24 - Resident to resident physical abuse

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

Infection Prevention and Control  
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)

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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 protect a resident from abuse by co-resident when they were not monitored after exhibiting a new behaviour.

A resident exhibited a new responsive behaviour on a specific date when they entered a co-resident's room and was physically aggressive towards the co-resident. The resident did not have any changes in the plan for care for intervention to mitigate further incidents. They did not receive enhanced monitoring (DOS) and subsequently, two days later, entered another co-resident's room and a physical altercation took place causing injury.

**Sources:** Clinical health records for the resident 001, 002, and 003, CI ; interviews with the DOC and BSO lead.

**WRITTEN NOTIFICATION: Responsive behaviours**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with:** O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident demonstrated a responsive behaviour that actions were taken to respond to the needs of the resident, including assessment and interventions.

On a specific date a resident entered a co-resident's room and was physically aggressive towards the co-resident. Two days later the resident entered another co-resident room and a physical altercation took place causing injury. An assessment was not completed in response to the new

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behaviour related to the first incident and no new interventions were added.

**Sources:** Clinical health records for the resident 001, 002, and 003 CI ;  
interviews with the DOC and BSO lead.

**WRITTEN NOTIFICATION: Behaviours and altercations**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with:** O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that a resident was protected from risk of harm by a co-resident when a new responsive behaviour was identified and the licensee did not complete an assessment or implement further interventions to mitigate further incidents. The resident subsequently entered another co-resident's room two days later and a physical altercation took place causing injury.

**Sources:** Clinical health records for the resident 001 and resident 002, CI ; and interviews with the DOC and BSO lead.