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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 24, 2025
Inspection Number: 2025-1147-0001
Inspection Type: Critical Incident
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Hope Street Terrace, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 - 24, 2025

The following intake(s) were inspected:

- Intakes- Related to a incident that lead to hospitalization of the resident.
- Intake - Related to neglect of a resident.
- Intake - Related to an incident related to nutrition for a resident.
- The following intakes were completed in this inspection: Intake related to a fall.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dining and snack service

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to ensure that the home dining' service had a process that Dietary Aide (DA) was aware of with regards to a resident's specific interventions.

Specifically, the required diet texture was not provided for a resident, because the DA was not aware of the process to ensure the appropriate texture was provided to the resident, this lead to an incident.

Sources: Resident records; Interviews with Nutrition Manager (NM) and DA

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