

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 23, 2026

**Inspection Number:** 2026-1147-0001

**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 12-14,16, 20, 23, 2026

The inspection occurred offsite on the following date(s): January 15, 19, 22, 2026

The following intake(s) were inspected:

- one intake regarding improper care of a resident.
- one intake regarding improper care of a resident.
- one intake regarding staff to resident physical abuse.

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

- Prevention of Abuse and Neglect
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Residents Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

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:

18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

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The resident indicated that while receiving personal care, privacy was not provided which caused the resident to feel embarrassed. The Registered Practical Nurse (RPN) confirmed the staff member exposed the resident while providing personal care.

**Sources:** Review of the resident's plan of care, the home's investigation notes and interview with staff and the resident.

## 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 care plan for the resident identified interventions to address specific behaviours. The resident was exhibiting behaviours prior to receiving care. The Personal Support Worker (PSW) indicated they found the resident receiving care against their will, while the PSW was providing care. The RPN provided emotional support to the resident as they were distraught over the incident.

**Sources:** resident's plan of care, investigation notes and interview with staff.

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1. The resident's care plan identified them as a resident with interventions. The transfer status for the resident was not followed. A team meeting confirmed the incident occurred because the intervention was not utilized.

**Sources:** resident's plan of care, interview with staff, and review of the homes falls management and prevention program policy.

2. The resident's care plan identified the resident to have a specific intervention in place for support.

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During care of the resident, an inappropriate intervention was utilized. The RPN confirmed the inappropriate intervention causing harm to the resident. The homes investigation notes confirmed the cause of the incident was not the correct intervention.

**Sources:** resident's plan of care, investigation notes and interview with staff.



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

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