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 West District
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: June 13, 2025
Inspection Number: 2025-1081-0003
Inspection Type: Critical Incident
Licensee: CVH (No. 8) 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: Errinrung Long Term Care Home, Thornbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10, 11, 12 and 13, 2025
The following intake(s) were inspected:

- Intake: #00147597 - Alleged resident-to-resident abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours

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.

The Licensee failed to ensure that a resident was protected from another resident.

A staff witnessed an incident of abuse between two residents.

Sources: CIS #2513-000015-25, Residents' clinical records, Interviews with staff and DOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee failed to ensure that appropriate action was taken in response to alleged resident-to-resident abuse.

A staff member witnessed an incident of alleged resident-to-resident abuse.

A risk management and pain assessment were completed for the resident, however, there was no documentation or indication that a head-to-toe assessment was completed.

Failure to complete and document a head-to-toe assessment after the incident, may result in missed signs of possible injuries or trauma and delays in getting the care that resident might need.

Sources: The home's policy titled Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy #RFC-02-01, CIS #2513-000015-25, Residents' clinical records, Interviews with staff and DOC,