

**Ministry of Long-Term Care**

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

**Central West District**

609 Kumpf Drive, Suite 105  
Waterloo, ON, N2V 1K8  
Telephone: (888) 432-7901

**Public Report**

**Report Issue Date:** October 23, 2025

**Inspection Number:** 2025-1081-0006

**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): October 14-16, 21-23, 2025

The following intake(s) were inspected:

- Intake: #00155636, related to concerns with continence care and safe lifts and transfers
- Intake: #00156352, related to alleged sexual abuse
- Intake: #00158423, related to alleged physical abuse

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

Continence Care  
Resident Care and Support Services  
Prevention of Abuse and Neglect

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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.

In accordance with FLTCA s.154 (3), the licensee is vicariously liable when a staff member has not complied with subsection 28 (1) of the FLTCA.

The licensee has failed to ensure that a suspected incident of resident-to-resident abuse was reported to the Director immediately. The suspected incident occurred on August 24, 2025, this was not reported to the DOC until 2 days later. The suspected incident was not reported to the Director until August 26, 2025.

**Sources:** Critical Incident Report. Interview with Director of Care (DOC)