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: December 17, 2025
Inspection Number: 2025-1121-0007
Inspection Type: Critical Incident
Licensee: CVH (NO. 11) 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: MacKenzie Place, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 15, and 17, 2025

The following intake(s) were inspected:
- An intake related to alleged staff to resident neglect and verbal abuse.
- An intake related to alleged staff to resident physical abuse.

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

Prevention of Abuse and Neglect

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) 2.
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:
2. Every resident has the right to have their lifestyle and choices respected.

Resident #001 reported that on an identified shift, staff did not respect their request with a personal need. As observed in the video footage, and documented in the home's investigation notes from the interview with Personal Support Worker (PSW) #102, the staff provided a different type of care, and not the one requested by the resident.
The Executive Director (ED) confirmed the staff was expected to respect the resident's choices.

Sources: Critical Incident Report (CIR), the home's investigation notes, video footage, and interviews with resident #001 and staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

Resident #001 called for help during a specific shift and requested assistance. PSW #101 answered the call bell and immediately exited the resident's room, as observed in the video footage reviewed. The resident reported PSW #101 told them to wait for the next shift staff, and did not provide the requested care. The ED indicated the expectation was the staff would have assisted the resident upon request.

Sources: CIR, the home's investigation notes, video footage, and interviews with resident #001 and staff.

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