

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

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Public Report

**Report Issue Date:** October 24, 2025

**Inspection Number:** 2025-1106-0006

**Inspection Type:**

Complaint  
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:** Oak Terrace, Orillia

## INSPECTION SUMMARY

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

The following intake(s) were inspected:

- One intake, related to a disease outbreak;
- One intake, related to an allegation of neglect; and,
- One intake, related to a complaint regarding the care of a resident.

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

Resident Care and Support Services  
Infection Prevention and Control  
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of care

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

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

A resident required assistance from staff to perform activities of daily living (ADL)s, and had other interventions in place to be implemented during a specified time frame. On one occasion, the resident did not receive any assistance to perform ADLs, and staff did not implement other interventions during the specified time frame.

Sources: A resident's care plan and Point of Care (POC) documentation; the home's investigation notes; interviews with a Registered Practical Nurse (RPN), and the Director of Care (DOC).