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

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Public Report

Report Issue Date: November 5, 2025
Inspection Number: 2025-1046-0007
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: Heartwood, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28, 29, 30, and 31, 2025 and November 3, and 4 2025.

The following intake(s) were inspected:
· Intake: #00160021 - Alleged neglect of a resident by staff.
· Intake: #00160227 - Complaint with concerns regarding alleged neglect of a resident.
· Intake: #00160495 - Alleged neglect of multiple residents.

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

Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

1) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan. Specifically, the resident was not monitored hourly using the 4 P's, which included turning, repositioning, and toileting, as specified in the resident's plan of care and confirmed by the Director of Care (DOC).

Sources: resident's electronic health record, the home's Critical Incident file, and interview with the DOC.

2) The licensee has failed to ensure that the care set out in the plan of care for two residents, related to their continence care and bowel management, was provided as specified in the plan.
Specifically, the Personal Support Workers (PSWs) did not follow the resident's documented plan of care related to toileting.

Sources: Internal investigation notes, Critical Incident Report , resident health care records, and an interview with the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the home's Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy requires that anyone who witnesses or suspects neglect that causes harm or risk of harm to a resident must report this incident immediately to management of the home.

Staff members reported to the Director of Care (DOC) that multiple residents had been neglected by staff during a specific period of time. The incident of alleged neglect was discovered but was not reported to management until the next day.

Sources: Internal investigation notes, Critical Incident Report, Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy and interview with the DOC.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that multiple residents who required continence care products to manage their continence had sufficient changes to remain clean, dry and comfortable on a specific date.

Sources: Resident's care plans, internal investigation notes, Critical Incident Report and interview with the Director Of Care.