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: March 19, 2026

Inspection Number: 2026-1147-0002

Inspection Type:
Critical Incident
Follow up

Licensee: CVH (No. 6) 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: Hope Street Terrace, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11-13, 16-19, 2026.

The following intakes were completed in this Critical Incident (CI) inspection:
- one intake related to staff-to-resident abuse.
- one intake related to staff-to-resident abuse.

The following intakes were completed in this Follow-Up inspection:
- one intake related to a compliance order regarding accommodation services.
- one intake related to a compliance order regarding housekeeping.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

-An order related to accommodation services.
-An order related to housekeeping.

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

Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident's plan of care indicated the resident required a specific intervention. The resident's clinical records and staff interviews confirm that specific intervention was not provided.

Sources: a resident's clinical records, the home's Safe Resident Lifts and Transfer policy, a critical incident report, and interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

On a specific date, a staff provided care to a resident without implementing a required intervention identified in the resident’s care plan. This intervention is identified to mitigate changes in behaviour. Review of the resident’s clinical records and interviews with staff indicated that the specific intervention was not consistently implemented.

Sources: a resident's clinical records, the home's Responsive Behaviors policy, a critical incident report, and interviews with staff.

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