

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: October 20, 2025 Inspection Number: 2025-1060-0002

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: Eagle Terrace, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 20, 2025

The following intake(s) were inspected:

-An intake related to the fall of a resident.

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

Infection Prevention and Control Falls Prevention and Management

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 (10) (b)

Plan of care

- s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or



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The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change.

On a specified date, a resident experienced a fall resulting change in condition. A specified intervention was ordered by the physician but was discontinued after a specified period. Upon reviewing clinical records, it was noted that the specified intervention was listed as still active despite being discontinued. Staff indicated that they had ceased the intervention some time prior.

Sources: Observations, resident's clinical records, interview with staff.



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