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: November 24, 2025
Inspection Number: 2025-1060-0003
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): November 17, 18, 19, 2025

The following intake(s) were inspected:

- One intake related to physical and emotional abuse of a resident by staff.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Ontario Regulation 246/22 defined physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain and, defined emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

A resident indicated that a Personal Support Worker (PSW) entered their room and attempted to remove the resident from their bed by pulling on their legs until the resident was at the edge of their bed and began yelling for other staff members to help. The resident further indicated that the PSW removed the call bell from the wall and stated to resident “try using the call bell now.”

A Registered Staff member responded to the incident and removed the PSW from the home area.

The investigation file indicated witnessed accounts for the PSW stumbling towards the punch clock, stumbling on the home area, and glazed eyes. The PSW acknowledged that they had been under the influence of medication and continued to work.

The Executive Director (ED) indicated that the PSW was no longer employed in the home.

Sources: Critical Incident Report**,** Policy titled “Zero tolerance of resident abuse, Neglect and Unlawful conduct, Policy RFC-02-01, last revised August 2025, resident's clinical records, internal investigation records, interviews with the resident and other staff.

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