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:** August 5, 2025

**Inspection Number:** 2025-1083-0004

**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:** Thorntonview, Oshawa

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 25, 29-31, 2025 and August 1 and 5, 2025

The following intake(s) were inspected:

- One Intake related to resident to resident abuse.
- One Intake related to a fall with injury
- One Intake related to alleged Improper care of a resident
- One Intake related to a complaint regarding alleged improper care

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

Resident Care and Support Services
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: ORAL CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)**
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received oral care to maintain the integrity of the oral tissue that included the cleaning of dentures.

A complaint was submitted to the MLTC related to allegations of improper care of a resident. On a specified date, the resident 's health condition deteriorated leading to the resident being transferred to a medical facility. The complainant alleged upon arrival to the medical facility that no oral care was done to the resident.

The resident's plan of care indicated that the resident required oral care. staff confirmed that the required oral care was not done.

**Sources:** The resident's care plan, and interviews with staff.

## WRITTEN NOTIFICATION: PERSONAL ITEMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)**

Personal items and personal aids

s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee has failed to ensure that personal items were labelled.

During observations the inspector observed a bathroom shared between two residents to have personal items without a label.

**Sources:** Observations.

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