

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 14, 2025

Inspection Number: 2025-1083-0006

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: Thorntonview, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8-10, 14, 2025

The following intake(s) were inspected:

- ▢ An intake related to a fall incident, that resulted in an injury of a resident.
- ▢ An intake related to a physical altercation between residents.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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.

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

The licensee failed to ensure a resident was protected from physical abuse by another resident.

According to Ontario Regulation 246/22, the definition of physical abuse means the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident Report (CIR) was submitted to the Director related to a resident to resident altercation. A resident sustained an injury from this incident.

Sources: Resident's clinical records, CIR, video surveillance, 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) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken to respond to the needs of a resident demonstrating responsive behaviours. A responsive behaviour assessment was not completed as per policy, following an incident of resident to resident altercation.

Sources: Resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations

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

and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that interventions were implemented to minimize the risk of potentially harmful interactions between co-residents.

Sources: Resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to notify the Director not later than three business days following an injury that was undetermined if it result in a significant change in resident's health condition. A resident sustained an injury from an unwitnessed fall incident and was transferred to hospital for further assessment. A CIR was submitted seven business days later confirming a significant change in the resident's health status.

Sources: Resident's clinical records, CIR, and interview with staff.



Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702