

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: December 4, 2025

Inspection Number: 2025-1843-0001

Inspection Type:
Critical Incident

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited

Long Term Care Home and City: Northern Heights Community, North Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25-27, 2025.

The following intake(s) were inspected:

- Two intakes, related to physical/ verbal abuse of resident; and,
- One intake, related to a resident's fall incident.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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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

1. Staff implemented a specific intervention for a resident to mitigate a risk. This intervention was not noted in the resident's care plan.

The plan of care was reviewed on a specified date, and it included the specific intervention.

Sources: resident health care records, observations; interviews with the resident, the Executive Director (ED) and other staff.

2. A resident's plan of care specified that they required a specific intervention to be used. The resident's room was observed on a specific date, and the intervention was not in place. The Behavioural Supports Ontario (BSO) Lead identified that this intervention was discontinued and should have been removed from their plan of care.

The plan of care was subsequently reviewed, and it was noted that the intervention had been removed from the resident's care plan.

Sources: resident's health care records; observations; interview with the BSO Lead.

Date Remedy Implemented: November 27, 2025

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WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On a specified date a PSW provided care to a resident, however they did not follow the resident's care plan.

Sources: Critical Incident report, home's investigation file, resident progress notes and care plan, resident and DOC interview.

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

On a specified day, a staff member did not document the care they provided to a resident.

Sources: resident's health records; and a staff interview.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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The home's policy identified the requirement of the nurse in charge to contact the ED or designate of any witnessed, suspected incident of abuse of a resident. The ED identified that the implementation of the home's process to manage an incident of abuse was not followed when the staff member did not contact the on-call manager to report the incident and receive further direction.

Sources: home's policy, resident health care records, investigation notes; interviews with the ED and other staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On a specified date, an altercation occurred. A critical incident report that alleged abuse of a resident was not submitted to the Director until a day later.

Sources: Critical Incident report; resident progress notes; and interviews with ED and other staff.



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

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