

**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:** July 16, 2025

**Inspection Number:** 2025-1138-0003

**Inspection Type:**

Critical Incident

**Licensee:** CVH (No. 6) 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:** Port Perry Place, Port Perry

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 7-10 and July 14-16, 2025

The following intake(s) were inspected:

- An intake related to an incident that caused injury to a resident that resulted in a significant change in the resident's health status

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

Food, Nutrition and Hydration  
Infection Prevention and Control

## INSPECTION RESULTS

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## **WRITTEN NOTIFICATION: Dining and snack service**

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.**

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

3. Monitoring of all residents during meals.

The licensee failed to ensure that the home's dining service included monitoring of all residents during a meal service on a particular Resident Home Area (RHA) on a specific date. A Personal Support Worker (PSW) was the only staff member present in the dining room on a certain date. The home's Executive Director (ED) confirmed that all PSW staff and the registered staff for the RHA were expected to be present in the dining room for the duration of the meal service.

**Sources:** Observation, the home's staff schedule, the home's internal investigation notes, and interviews with staff.

## **COMPLIANCE ORDER CO #001 Duty to protect**

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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 inspector is ordering the licensee to comply with a Compliance Order**

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**[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall ensure the following:

1. The Executive Director (ED) and/or the Director of Care (DOC) will develop and implement a process to track the First Aid and CPR certification status for all registered staff in the home. The home will ensure that all registered staff working in the home have provided proof of Standard First Aid with CPR BLS certification and that their certification is current/valid. The tracking process must include the names of all the registered staff, the level of First Aid/CPR completed, the date in which the certification was completed, the authority issuing the certification, and the date in which the certification will expire. Any registered staff identified as not having valid certification are required to complete the certification by the compliance due date. Records are to be made available to the inspector upon request.
2. The home's DOC or a Registered Nurse (RN) designated by the DOC, will conduct a minimum of 9 mock Code Blue drills on the specified Resident Home Area (RHA), completed once per week on each shift (one on the day shift, one on the evening shift, and one on the night shift) for a period of three consecutive weeks. Mock Code Blue drills must include scenarios of responding to choking incidents and must cover instances where the person choking is in a wheelchair as well as larger in size than the person responding. The home must keep a documented record of each mock Code Blue drill completed, including the date, time and shift, as well as the full names and professional designations of the staff participating. The documented record should outline the mock scenario, the steps completed by the staff as part of the Code Blue drill, and any corrective actions or feedback provided. The documented record is to be made available to the inspector upon request.

**Grounds**

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The licensee failed to ensure that a resident was protected from neglect by the staff, when they experienced an event during a specified activity on a certain date.

Section 7 of the Ontario Regulation 246/22 defines neglect as, "the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents."

A resident experienced an event during a specified activity on a certain date. Interventions were initiated by a staff member, however, were stopped while the staff member completed a page on the announcement system, leaving the resident unattended during the event.

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The home's policy indicated that staff are to assign a second person to alert a registered staff to make an announcement and that staff are to "ensure 9-1-1 has been called."

Staff responding to the event made the decision to transfer the resident, which also resulted in interventions being stopped during the transfer.

There was a delay in contacting Emergency services/911. The critical incident resulted in a significant change to the resident's health status.

The home's procedures indicated that all registered staff must provide proof of Standard First Aid with CPR BLS certification and maintain current certification for the entire duration of their employment. Registered staff members responding to the event did not have current First Aid and CPR certifications.

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Due to a failure to provide continuous and appropriate interventions while the resident experienced an event, the resident did not receive the treatment or care required for their health. The delay in telephoning emergency medical services also further decreased the resident's access to life saving measures.

**Sources:**

Critical Incident Report (CIR), health records for a resident, the home's internal investigation notes, the home's policies and procedures, and interviews with registered staff, the DOC, and the ED.

**This order must be complied with by**

August 27, 2025

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**COMPLIANCE ORDER CO #002 Dining and snack service**

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.**

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

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**The inspector is ordering the licensee to comply with a Compliance Order  
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall ensure the following:

1. The DOC or a nurse (RN or RPN) designated by the DOC, along with the home's Registered Dietician will provide in person education to all of the staff members on the specified Resident Home Area that provide assistance or supervision during the meal times. The education must include review of the different levels of assistance that residents on the home area may require with eating, how to implement each level of assistance, how to confirm the level of assistance, and the process for staff if clarification is required. The home is to maintain records of the education including, the full name and designation of the staff participating in the education, the date of the education, the contents of the education provided, and the signature of the staff member participating to acknowledge completion of the required education. The home will maintain the records and make them available to the inspector upon request.
2. The DOC or designate will complete auditing of the dining service on the specified Resident Home Area, for three meals a week (one breakfast, one lunch, and one dinner service) for a period of three consecutive weeks to ensure that all residents on the home area are receiving appropriate assistance as outlined in their plan of care. The home's audit records must include the date of the audit, the name of the auditor, the meal audited, details of the level of assistance provided to residents that require assistance,

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confirm if residents received the required assistance, and document any corrective actions or feedback provided in the process. The home is to maintain the records and provide them to the inspector upon request.

**Grounds**

The licensee failed to ensure that the home provided a resident with personal assistance, which was required for them to eat as safely and independently as possible.

The resident received their meal on a specific Resident Home Area on a certain date. The resident's health records included instructions regarding the required assistance during meals, however, the instructions were not followed and the resident did not receive the required assistance on this date. The resident experienced an event that resulted in a significant change in their health status.

**Sources:**

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Critical Incident Report, health records for a resident, the home's internal investigation notes, and interviews with a PSW, registered staff, the DOC, and the ED.

**This order must be complied with by**

August 27, 2025

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).