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 West District
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: September 12, 2025

Inspection Number: 2025-1205-0006

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: Forest Heights, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 4, 5, 9-12, 2025

The following intake(s) were inspected:

-Intake: #00153327 - Related to allegation of improper care of a resident.
-Intake: #00154949 - Related to responsive behaviour of a resident.
-Intake: #00156126 - Related to allegation of abuse of a resident.
-Intake: #00157297 - Concerns related to Admissions, Absences and Discharge.

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

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 licensee has failed to ensure that a resident was protected from physical abuse by another resident that resulted in an injury.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Sources: Review of a resident's medical records and interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents.

Sources: Observations, review of medical record of the residents 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
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 and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The licensee has failed to ensure that a resident's plan of care was updated with interventions for the management of their responsive behaviours and that a direct care staff was informed of the interventions at the beginning of their shift.

Sources: Review of the resident's medical 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 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident and they were transferred to hospital.

Sources: Review of resident's medical records, interviews with staff.

WRITTEN NOTIFICATION: When licensee shall discharge

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 158 (4) (b)
When licensee shall discharge
s. 158 (4) A licensee shall discharge a long-stay resident if,
(b) the resident is on a psychiatric absence that exceeds 60 days;

The licensee has failed to ensure that 60 day psychiatric absence limit was followed before a resident was discharged from the home.

Sources: Medical record review of the resident, review of the discharge records, review of the homes Resident Focused Discharge Process and interview with staff.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (1) (a)
Requirements on licensee before discharging a resident
s. 161 (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or

The licensee has failed to ensure that before a resident was discharged, notice of the discharge was given to their substitute decision-maker as far in advance as possible.

Sources: Medical record review of the resident, review of the discharge records, review of the homes Resident Focused Discharge Process and interview with staff.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee has failed to ensure that before discharging a resident, they made alternative arrangements for the resident in collaboration with an appropriate placement coordinator.

Sources: Medical record review of the resident, review of the discharge records, review of the homes Resident Focused Discharge Process and interview with staff.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The licensees has failed to ensure a resident's substitute decision-maker was kept

informed and given an opportunity to participate in the discharge planning and their wishes were taken into consideration, before discharging the resident.

Sources: Medical record review of the resident, review of the discharge records, review of the homes Resident Focused Discharge Process and interview with staff.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee has failed to ensure that before discharging a resident, they provided a written notice to the resident's substitute decision-maker, setting out a detailed explanation of the supporting facts and justify the licensee's decision to discharge the resident.

Sources: Medical record review of the resident, review of the discharge records, review of the homes Resident Focused Discharge Process and interview with staff.