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

Toronto District
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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: October 23, 2025
Inspection Number: 2025-1212-0005
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: Humber Valley Terrace, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15-17, 21, 23, 2025

The following intake(s) were inspected in this complaint inspection:

- Intake: #00156107- related to resident care and service.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00156076 / CI #2716-000035-25/2716-000036-25 - related to improper care.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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.

The licensee has failed to ensure that care set out in the plan of care was provided to resident as specified in their plan. Resident's care plan directed that the resident's equipment to be kept at a specific position and an intervention placed in the resident's room. However, an observation revealed that the equipment was not at the specified position and the intervention was missing in the resident's room.

Sources: Inspector's Observations; a review of the resident's plan of care; interview with the Personal Support Worker (PSW).

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe positioning techniques when assisting a resident in the bed. The resident's plan of care indicated a specific level of assistance was needed while in bed. On a specific date, A PSW did not provide the required level of assistance to the resident, which subsequently resulted in a fall incident and negative health outcome for the resident.

Sources: Resident’s clinical records; Home's Investigation Notes and interview with the PSW.