Ontario

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

Toronto District
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: October 21, 2025
Inspection Number: 2025-1212-0004
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: Humber Valley Terrace, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15-17, 20, and 21, 2025

The following intakes were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00154553/CIS #2716-000030-25 and Intake: #00159088/CIS #2716-000037-25 were related to fall prevention and management.
- Intake: #00155140/CIS #2716-000032-25/2716-000034-25 was related to a residents' care and services.

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

Resident Care and Support Services
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 the plan of care was provided to two residents as specified in their plans.

i) A resident was at high risk for impaired skin integrity due to their health conditions, requiring staff to follow a specific intervention as per their plan of care. During an observation conducted on an specified date, the resident's care planned intervention was not followed by the staff as required.

Sources: Resident's clinical records; interviews with the Personal Support Worker (PSW) and Registered Nurse (RN).

ii) A resident’s care plan directed staff to implement specific fall interventions for the resident while they were in bed. However, on an specified date, these fall interventions were not implemented.

Sources: Observation, resident’s clinical records, and interviews with PSWs.