

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

Toronto District  
5700 Yonge Street, 5th Floor  
Toronto, ON, M2M 4K5  
Telephone: (866) 311-8002

## Public Report

**Report Issue Date:** February 5, 2026

**Inspection Number:** 2026-1212-0001

**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): January 27-28 and February 2-5, 2026

The inspection occurred offsite on the following date(s): January 29-30, 2026

The following intakes were inspected in this Critical Incident (CI) Inspection:

-Intake: #00163971 - [CI: #2716-000041-25] - related to alleged staff to resident verbal abuse

-Intake: #00164546 - [CI: #2716-000042-25] - related to resident care and services

-Intake: #00164884 - [CI: #2716-000043-25] - related to a resident fall which led to injury

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

- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- 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.

A resident had required a specific intervention to be completed at timed intervals to monitor their health condition, however one of the checks was not completed.

**Sources:** Resident's clinical records, home's diabetes management policies, and interviews with staff.

### WRITTEN NOTIFICATION: Duty to Protect

NC #002 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.

Section 2 of the Ontario Regulation (O. Reg.) 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Two staff members witnessed a Personal Support Worker (PSW) raise their voice at a resident. After the incident, the resident was upset and crying.

**Sources:** Resident's progress notes, home's investigation notes, and interviews with staff.

### WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

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NC #003 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.

Two staff members witnessed an incident of verbal abuse from a PSW towards a resident. Both staff members did not report the incident immediately to a registered staff member or management in accordance with the home's abuse policy.

**Sources:** Resident's progress notes, home's investigation notes, home's abuse policy, and a interview with a staff member.

## WRITTEN NOTIFICATION: Required Programs

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

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Following a fall incident, a PSW assisted a resident off the floor to a chair prior to an assessment by a registered nursing staff.

**Sources:** Home's falls policy, home's investigation notes, and interviews with staff.