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

Public Report

Report Issue Date: March 18, 2026
Inspection Number: 2026-1212-0003
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): March 4- 6, 9, 11-13, 16 and 18, 2026

The inspection occurred offsite on the following date: March 17, 2026.

The following intakes were inspected in this Critical Incident (CI) inspection:
-Intake: # 00168087/ CI #2716-000004-26 related to concerns of malnutrition
-Intake: # 00169773/ CI #2716-000006-26 and Intake# 00170200/ CI #2716-000007-26 related to concerns of improper care
-Intake: #00170735/ CI # 2716-000008-26 related to fall with injury

The following intakes were inspected in this complaint inspection:
-Intake: #00169688 complaint related to allegations of improper care resulting in altered skin integrity
-Intake: # 00170040 complaint related to allegations of improper wound care

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Pain Management
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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A Registered Practical Nurse (RPN) documented that a resident had refused a particular aspect of care and that the family was notified of the refusal. However, care records indicated that the care was completed by the staff. Furthermore, two Personal Support Workers (PSWs) indicated that the resident had received care, and this specific care intervention was also documented incorrectly in their care plan. However, the RPN was not made aware of these situations.

Sources: Resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 required a certain level of assistance for a specific intervention, however, there were multiple occasions where the intervention was not followed as per their plan of care.

Sources: Resident's plan of care, home's investigation notes; and interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (a)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;

A resident had a condition, which required a specific treatment. On a specified date, clinical records indicated that the condition no longer required the treatment, however it was not reflected in the plan of care.

Sources: Observations, review of medication administration record, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 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.

A PSW did not use safe transferring techniques when they assisted a resident following an incident.

Sources: Resident's health records, interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #005 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.

The home's Falls Prevention and Management Program policy directed staff to encourage the resident to remain in their current position until a registered staff member has assessed them after a fall.

A PSW assisted a resident prior to an assessment by registered staff following a fall

Sources: Resident's health records, the Long Term Care's policy, interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

A resident was scheduled for an assessment at fixed intervals. On a certain assessment, staff documented incorrectly.

Sources: Observation, pain assessment, LTC's policy, and interviews with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

A resident was assessed, and their written plan of care detailed a particular intervention. On a specified date, it was identified that the intervention was not in place.

Sources: Resident's health records, interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The Registered Dietitian (RD) was referred for a skin condition and made recommendations to a resident's plan of care. The recommendations were not implemented until several weeks later, after the RD reassessed the resident.

Sources: Resident's progress notes, Medication Administration Record, and interview with the staff.

COMPLIANCE ORDER CO #001 Duty to Protect

NC #009 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 [FLTCA, 2021, s. 155 (1) (a)]:
1. Conduct a meeting to review the identified resident's current specified strategies together with the most responsible staff, and management, and revise the plan of care

to ensure adequate interventions and at the required frequency, are implemented to address the resident’s needss. Maintain a record of the name and designation of the attendees, date and time of meeting, all records reviewed during the meeting, notes taken of the review and actions to implement, and any changes to the plan of care.
2. Provide re-education to all PSWs (including casual staff, agency, and students), assigned to the home's resident home area on the home's specified program and policies, including but not limited to: role of the PSW, identifying signs and symptoms in cognitively impaired residents, triggers and types, reporting to registered staff, and documentation expectations.
3. Provide re-education to all RPNs and RNs (including casual staff, agency, and students), assigned to the identified resident home area on the home's specified management program and policies including, but not limited to: identifying signs and symptoms of in cognitively impaired residents, triggers and types, completion of assessments in cognitively impaired residents, treating with appropriate strategies and interventions when triggers are identified, evaluating effectiveness of interventions, collaborating with PSW, physician, and other disciplines, documentation expectations, and how improper management of a resident's discomfort can result in neglect and the related consequences.
4. Maintain a record of the education completed in parts 2 to 3; including who attended the training, their designation, date and time, who conducted the training, and topics and content covered in the training.
5. Develop and implement an audit of nurses performing in-person specified assessments on the resident to ensure any signs are identified and documented using the appropriate assessment tool. Conduct at minimum two audits on the day shift and two audits on the evening shift each week, for a period of two weeks following the service of this order.
6. Maintain a record of audits completed in part 5, including the date and time, name and designation of nurse audited, results of audits and actions taken in response to the audit findings.

Grounds

In accordance with the definition identified in Ontario Regulation 246/22 section 7, “neglect” means 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 did not receive a specific intervention during a particular timeframe. The resident sustained a negative health outcome which caused discomfort.

i) During an observation, the resident was noted to verbalize discomfort when receiving care and staff noted the resident's discomfort.

ii) The resident had a condition that required a specific assessment tool to be used to assess their pain, however on multiple occasions, the tool was not utilized.

During a specific timeframe, staff documented the resident's specific levels incorrectly.

Staff acknowledged that the resident's pain level would have have been documented differently if the appropriate tool was used.

iii) On all shifts during a specific time period, staff documented no signs of discomfort were observed, however staff indicated the resident exhibited signs of discomfort during a specific intervention which they should have documented. However, another staff stated the resident did seem to exhibit discomfort during a specific intervention.

iv) The physician was not informed that the resident exhibited signs of discomfort, and was not given an opportunity to collaborate in the assessment and treatment of their condition. .

The home acknowledged that when the resident exhibited discomfort during the specified time period, they experienced neglect.

Failure to provide the resident with appropriate and accurate assessments, collaborate with the physician, and provide the required treatment or interventions jeopardized the health and well-being of the resident.

Sources: Observations; the resident's care plan, progress notes, Medication Administration Record (MAR), assessments, documentation survey, home's investigation notes, home's policy, and interviews with staff.

This order must be complied with by April 30, 2026

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, 8th floor
Toronto, ON, M7A 1N3
e-mail: 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:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.