

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: November 17, 2025

Inspection Number: 2025-1143-0004

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: ReachView Village, Uxbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 27-31, 2025 and November 3-7, 2025

The following intake(s) were inspected:

- Intake #00159020 was related to alleged resident to resident sexual abuse
- Intake #00159540 was related to unknown Outbreak
- Intake #00161000 was related to complainant related to alleged resident to resident sexual abuse
- Intake #00161363 was related to complainant related to alleged resident to resident sexual abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On an identified date, the Licensee became aware, and had reasonable grounds to suspect the sexual abuse of resident by another resident. The licensee did not immediately report the suspicion and matter to the Director until the following day.

Sources: Residents' clinical records, home's internal investigation notes and interviews with the staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 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. The licensee shall provide training to all direct care staff (staff who interact with residents through the provision of care, which includes Nursing Staff, Personal Support Workers, Recreation Staff, and Dietary Aides) with regards to the prevention of Abuse and Neglect of residents. At a minimum the training must include information on:

A) What constitutes abuse under the FLTCA and, how to identify and respond to abuse, with a special focus on sexual abuse.

B) What constitutes consent and how to assess consent in the context of resident-to-resident relationships, including who can and cannot give consent, and how to determine whether consent is present in the context of a population with declining cognitive abilities.

2. The licensee shall maintain a written record of all trainings provided, including the date(s) the trainings was provided, who provided the training and the names and

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signatures of all staff in attendance as well as a copy of all material covered in the training.

3. The licensee shall develop and implement a written strategy that will identify actions that may be used by direct care staff, supervisors, and managers to keep residents protected from sexual abuse, including screening protocols for at-risk residents, interventions/strategies to monitor at-risk residents and follow-up actions that can be taken with staff.

4. The licensee shall educate all direct care staff and supervisors/managers on the strategy (mentioned above in part 3) and must keep a written record of this education, including the content of the education, names and signatures of staff who received education, date(s) the education was provided and name (s) of individual (s) providing the education.

5. The licensee must consult with an external resource for assistance in developing and planning appropriate interventions to support the needs of resident #002 and mitigate the risk of ongoing sexual behaviours towards resident #001 as well as other residents lacking capacity to consent to sexual behaviour.

Grounds

Under the Fixing Long-Term Care Act, 2021 (s. 2(1)), "abuse" includes "sexual abuse" as defined in the regulations. Ontario Regulation 246/22 (s. 2(1)) defined "sexual abuse" as including "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

On an identified date, the Ministry of Long-Term Care (MLTC) received a Critical Incident Report (CIR) from the Long-Term Care Home (LTCH) as well as a complaint with regards to alleged sexual abuse of a resident by another resident.

Video footage provided by the LTCH showed a resident having repeated physical interactions with a co-resident on numerous occasions over an identified period of time. On multiple occasions the identified resident was observed to direct the co-resident to the co-resident's bedroom where they then proceeded to engage in physical contact with the co-resident who lacked the capacity to provide consent. The identified resident was also observed to attempt to transfer the co-resident, who has specified interventions related to transferring noted in their care plan. There was also an occasion observed in video provided by the LTCH in which the identified resident was observed

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to restrict the movement of the co-resident both verbally and physically.

On one occasion, staff were observed in video footage to enter the co-residents room and separate the two residents. On a separate occasion a separate staff member was observed to enter the room of the co-resident while both residents were in the room, and the identified resident was acting out sexually towards the co-resident. The staff member was observed to exit the room, leaving the two residents in the room together. The identified staff was observed to exit the resident home area (RHA), walking past at least one additional staff member. A short time later a separate staff member attended the room and was observed on camera to be gesturing to another staff while they remained in the doorway of the co-resident. The additional staff was then observed to exit the RHA. A short time later the staff who initially discovered in the residents in the co-resident's room returned to the RHA with a member of the registered staff. The registered staff was observed to direct the resident out of the co-resident's room, however the resident remained outside the door of the co-resident's room, re-entering the room after the staff had left the area.

During an interview with direct care staff, it was reported that the identified resident continued to seek out the co-resident and would become escalated when they were told that they were not permitted to seek out the co-resident. A review of the resident's care plan showed that while there were interventions outlined, there was an absence of any interventions relevant to sexually responsive behaviours or behaviours in which the resident was seeking out the co-resident and there was an absence of referrals to external resources.

A review of investigation notes from the LTCH showed that the staff who initially discovered the resident in the co-resident's room indicated that they had not separated the staff as they did not see that there was any danger to the co-resident. The same investigation notes showed that an additional staff who had been interviewed identified that they had been directed to retrieve staff as the matter was very serious and required intervention. Additionally, during an interview with a member of the registered staff at a later time, the registered staff was able to identify that in their view, this was a very serious matter. Despite the registered staff's view that this was a serious matter, a member of the management team reported during an interview that they did not view this as a serious matter until the following day when a specified individual expressed concerns to the LTCH.

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Given that the co-resident has been identified as being unable to provide consent for sexual activity as well as specified health indicators, the resident is at high risk of negative health outcomes as well as high risk of being sexually exploited by the identified resident.

Sources: Video footage, residents' clinical records, LTCH investigation notes and interviews with staff.

This order must be complied with by December 30, 2025

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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

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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
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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.



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Fixing Long-Term Care Act, 2021**

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