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

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

Public Report

Report Issue Date: March 4, 2026
Inspection Number: 2026-1143-0002
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): February 26-27 and March 2-4, 2026.

The following intake were completed in this complaint inspection:
• one intake related to safety of a resident.

The following intakes were completed in this Critical Incident (CI) inspection:
• one intake related to improper care of a resident.
• one intake related to resident-to-resident abuse.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

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) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A complaint was received involving two residents. Records indicated interventions in place for a resident. Further review of documentation revealed recommendations from the interdisciplinary team. Staff acknowledged that other interventions could have been implemented for the resident.

Sources: Resident records, policies, observations and interviews with staff.

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.

On a specific date, a staff transferred a resident without the required level of assistance.

Sources: Resident records, a CI report, the home's investigation file, policies, and interviews with staff.

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