

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: June 5, 2025

Inspection Number: 2025-1208-0003

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: Sara Vista, Elmvale

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-5, 2025.

The following intake(s) were inspected:

-Intake: #00147394, related to an allegation of resident abuse.

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

Continence Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

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

Reporting certain matters to Director

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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.

The licensee failed to ensure when a Personal Support Worker (PSW) suspected neglect of a resident, that they reported their suspicion and the information upon which it was based to the Director.

During an assessment of a resident, a PSW reported to a Registered Practical Nurse (RPN) that they suspected care was not provided to a resident for an extended period of time. The PSW or the RPN on duty did not report their suspicion to the home's management team or Director until 3 days later.

Sources: Review of resident's progress notes, Critical Incident Report, interview with PSW's and the Executive Director.