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

Hamilton District
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Public Report

Report Issue Date: May 29, 2025
Inspection Number: 2025-1095-0003
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: BayWoods Place, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27 - 29, 2025

The following intake was inspected:

- Intake: #00146613 - Critical Incident (CI) #2581-000031-25 - relating to prevention of abuse and neglect.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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.

The licensee has failed to protect a resident from physical abuse. Section 2 of the Ontario Regulation (O. Reg 246/22) defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

A resident walked into another resident's room that resulted in an altercation between the residents. One resident punched the other resident which resulted in an injury.

Sources: Video Footage, skin and wound assessment, post fall assessment and interview with resident.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours.

A resident's plan of care indicated that they would wonder into other residents rooms and staff were to re-direct the resident when that occurred. On a specific date, a resident wondered into another resident's room and a staff did not re-direct them out of the room. An altercation occurred between the two residents which

resulted in an injury to one of the residents.

Sources: Video Footage, resident's plan of care and interview with Associate Director of Care.