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 West District
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Public Report

Report Issue Date: July 2, 2025
Inspection Number: 2025-1703-0003
Inspection Type: Critical Incident
Licensee: CVH (No. 3) 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: Southbridge Owen Sound, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-20, 23-26, 30, 2025, and July 2, 2025

The following intake(s) were inspected:

- Intake: #00146625 - CI #3061-000024-25: Alleged sexual abuse
- Intake: #00149760 - CI #3061-000029-25: Alleged physical abuse

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

Prevention of Abuse and Neglect
Responsive Behaviours

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 ensure that a resident was protected from abuse.

Ontario Regulation 246/22, 2 (1) (b) defines sexual abuse as,

(b) 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; ("mauvais traitements d'ordre sexuel")

Failure to implement sufficient interventions for the resident resulted in a resident being subjected to a second incident of abuse.

Sources: Resident's progress notes, plan of care, CIS report, interview with Environmental Services Manager, Director of Care

The licensee has failed to ensure that interventions were implemented to manage a resident's responsive behaviours which resulted in altercations with another resident.

There were three separate incidents that resulted in altercations between two residents, one of which resulted in an injury for the other resident.

Sources: Resident progress notes, CIS Reports, interviews with PSW Education Coordinator (PSW EC) and Registered Nurse (RN)

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.

The DOC confirmed that although there was a history of behaviors for the resident there were no interventions in the resident's care plan related to these behaviours at the time of the incident.

As a result of the home not developing and implementing interventions to manage the resident responsive behaviours another resident was subject to abuse.

Sources: Progress notes, care plan, CIS report, interview with Environmental Services Manager (ESM), Director of Care (DOC).

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and

among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that interventions were implemented to minimize the risk of altercations and potentially harmful interactions between two resident's.

There were three separate incidents that resulted in altercations between two residents, one of which resulted in an injury for the other resident.

Sources: Resident progress notes, plan of care, CIS Reports, interviews with PSW Education Coordinator (PSW EC) and Registered Nurse (RN).