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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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: December 1, 2025
Inspection Number: 2025-1703-0006
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): November 12, 14, 18-20, 24, 26, 2025 and December 1, 2025
The inspection occurred offsite on the following date(s): November 27, 2025

The following intake(s) were inspected:
-Intake: #00156791: resident care and support services.
-Intake: #00157540: falls prevention and management.
-Intake: #00160550: allegation of resident to resident physical abuse.

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

Resident Care and Support Services
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A staff member did not follow a residents plan of care related to bathing assistance, which negatively impacted the resident.

Sources: Interviews with a resident and staff, resident's clinical records.

WRITTEN NOTIFICATION: Duty to protect

NC #002 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.

Section 7 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

There was a resident to resident altercation that resulted in physical injury to a resident.

Sources: resident's clinical records, interviews with staff.