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: September 12, 2025

Inspection Number: 2025-1193-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) 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: Orchard Villa, Pickering

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 2-5, 8-12, 2025

The following intakes were inspected in this Follow-up (FU) inspection:
One follow-up intake related to CO #001/2025-1193-0003- FLTCA, 2021 - s. 6 (7) CDD July 11, 2025
One follow-up intake related to CO #004/2025-1193-0004- O. Reg. 246/22 - s. 23 (4) (b), cooling requirements
One follow-up intake related to CO #005/2025-1193-0004 - O. Reg. 246/22 - s. 24 (4) (a)
One follow-up intake related to CO #002/ 2025-1193-0004, FLTCA, 2021, s. 24 (1), Duty to Protect

The following intake(s) were inspected in this complaint inspection:
A complaint regarding housekeeping, plan of care and wound care for a resident
A complaint regarding the abuse of a resident

The following intake(s) were inspected in this Critical Incident (CI) inspection:
One incident related to alleged financial abuse
Two incidents related to falls with injury
Two incidents related to the improper care of residents
Two incidents related to resident-to-resident abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1193-0003 related to FLTCA, 2021, s. 6 (7)
Order #004 from Inspection #2025-1193-0004 related to O. Reg. 246/22, s. 23 (4) (b)
Order #005 from Inspection #2025-1193-0004 related to O. Reg. 246/22, s. 24 (4) (a)
Order #002 from Inspection #2025-1193-0004 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO BE TREATED WITH RESPECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to respect and uphold the resident's preference regarding the resident's caregivers.

The resident's care plan indicated that specific caregivers were to provide personal

care. Records indicated that for months, the resident's preferences were not followed.

Source: The resident's clinical records, POC Task documentation, interview with staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that a resident was free from abuse from another resident.

A report was submitted to the Director regarding a staff observation of an inappropriate interaction between residents. The staff noted that the interaction continued until the intervention separated the individuals. The resident involved expressed discontent with the interaction.

Sources: The CIS report, The residents' clinical health records, the home's investigation and interview with staff.

WRITTEN NOTIFICATION: RIGHT TO QUALITY CARE AND SELF-DETERMINATION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to provide care and services that met a resident's needs when a staff prevented a resident access to their accommodation.

On a specified date, an incident occurred where the resident was denied access to their accommodation. Follow-up investigation notes and staff interviews indicated that this practice happened multiple times with different residents.

Source: Home's investigation notes, The CIS reports, interviews with staff.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure that the home was kept clean and sanitary,

A complaint was submitted to the Director regarding inadequate cleanliness within the home. During the inspector’s observations, several areas of the home were found to be in poor sanitary condition and in need of repair.

Sources: Observations.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
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 that incidents of abuse were immediately reported to the

Director.

Multiple incidents involving alleged resident abuse were reported to the Director. The home's investigation records, residents' records, and staff interviews confirmed that the allegations were not reported immediately.

Sources: The CIS reports, the home's investigation notes, the residents' health records, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 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.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident who had fallen.

An incident was reported to the Director where a resident experienced a fall resulting in injury. The investigation notes and staff interviews confirmed that incorrect transfer techniques were used when assisting the resident after the fall.

Sources: Home investigation notes, the Falls Prevention and Management Program policy, and interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O.

Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure when a resident had a fall, that the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument.

An incident was reported to the Director, which indicated that a resident sustained a fall that resulted in injury. No post-fall assessments were completed with a clinically appropriate tool.

Sources: The resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (ii)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(ii) properly fit the residents,

The licensee has failed to ensure that a resident was provided with a continence product that fit the resident.

A complaint was submitted to the Director regarding concerns about a resident, including issues with continence care. The resident's care plan indicated they should always receive a specific size of incontinence product. Staff confirmed that when the required product was unavailable, the resident used a different one.

Sources: The resident's care plan, interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 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 failed to ensure that strategies were implemented to respond to a resident's responsive behaviours.

A resident had a history of responsive behaviours towards other residents. A strategy implemented by the home to manage the resident's behaviours was not implemented during the inspector's observations.

Sources: Observations, the resident's health records and interviews with staff.

WRITTEN NOTIFICATION: Police notification

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse and neglect of a resident.

An incident was reported to the Director regarding an allegation of abuse of a resident. According to the home's records, the resident alleged abuse and neglect. The resident's progress notes and staff interviews confirmed that the police were not notified until three days later.

Sources: The resident's progress notes, interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a resident submitted a verbal complaint to the home, that a response was provided to the resident.

An incident was reported to the Director involving an allegation of abuse. The home's complaint records showed that a resident made a complaint to the home. The home's complaint form and record of complaints indicated that no response was provided.

Sources: The home's complaint records, Interview with the DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
(1) Educate the management team on the complaint reporting, investigation and response policy, specifically on the investigation process to assess the staff’s compliance with meeting the resident’s needs. Ensure the education content includes case studies.
(2) Keep a documented record of the material reviewed, the date, name and title of who delivered the training and the name and title of who attended the training.
(3) The Regional Director will audit all allegations of abuse and neglect made to the

specified staff between the report issue date and the compliance due date, to ensure that they are compliant with the requirements under the Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct policy and the complaint reporting, investigation and response policy.
(4) Keep a record of the date and time of audit, staff performing the audit, result and actions taken if needed as a result of the audit.

Grounds

The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

Section 7 of the O. Reg 246/22 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The incident involved an allegation of inadequate care of a resident, reported to the Director. On a specific date, the resident indicated that their needs went unmet for about eight hours because they could not communicate. The investigation noted that staff assisted the resident, but they continued requesting help during this time. The care plan identified the use of a communication device with staff, which staff were unaware of. A staff member confirmed that the resident called for help, but they were unaware that the resident used a device to communicate. The device was not provided to the resident for roughly eight hours. The Director of Care acknowledged that failing to assist the resident with communication constituted neglect. The home's failure to provide assistance with communication caused the resident significant distress. As a result, the resident’s dignity, autonomy, and physical well-being were negatively affected.

Sources: The resident's plan of care, the home's investigation notes, and interviews with staff.

The licensee failed to protect residents from abuse and neglect by staff.

A resident filed a complaint with the Home alleging that a staff member restricted another resident's access to their bed by using a physical object. An investigation uncovered a pattern of incidents indicating abuse, neglect, and non-compliance with

individual care plans by a specific staff member. These issues affected the safety, dignity, and well-being of four residents and possibly others in a designated resident home area.

Source: Interview with staff, the homes' investigation notes.

This order must be complied with by November 21, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior NC with FLTCA s. 24 (1), resulting in CO #002 in Inspection #2025-1193-0004, issued on July 23, 2025; DO #001 in Inspection #2023-1193-0004, issued on June 28, 2023.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the

Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.