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: October 28, 2025
Inspection Number: 2025-1193-0006
Inspection Type:
Critical Incident

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): October 14 - 17, 20 - 24, 27-28, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
An intake related to the fall of a resident
An intake related to a resident-to-resident altercation
An intake related to a resident-to-resident altercation
An intake related to the Fall of a resident
An intake related to a resident-to-resident altercation
An intake related to a resident-to-resident altercation
An intake related to a resident-to-resident altercation
An intake related to an alleged staff-to-resident abuse
An intake related to a resident-to-resident altercation
An intake related to a resident-to-resident altercation
An intake related to a resident-to-resident altercation
An intake related to an allegation of improper care of a resident
An intake related to a resident-to-resident altercation
An intake related to the fall of a resident
An intake related to the fall of a resident
An intake related to a resident-to-resident altercation
An intake related to an allegation of improper care of a resident

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

Skin and Wound Prevention and Management

Responsive Behaviours
Prevention of Abuse and Neglect
Recreational and Social Activities
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure a resident was treated with courtesy and respect, and in a manner that fully recognized the resident's inherent dignity, when the resident lacked funds to meet their needs.

Sources: Interview with staff, clinical records for the resident.

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's right to be free from abuse was fully respected and promoted.

Sources: The residents' progress notes.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff collaborated in the assessment of a resident and in the implementation of the resident's plan of care to promote the resident's well-being. Specifically, the licensee failed to ensure collaboration among staff regarding assessment, communication, and follow-up.

Sources: resident’s clinical records, home’s investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #004 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 failed to ensure the resident was protected from a resident-to-resident abuse incident.

Sources: Critical Incident Report (CIR), home’s investigation notes, home's policy, clinical health records of residents, interviews with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that appropriate action was taken in response to allegations of resident-to-resident abuse.

Sources: Home's investigation notes, home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that the Director was immediately informed of an allegation of improper care or treatment of a resident.

Sources: Home's policy, interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 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 report a resident-to-resident abuse to the Director immediately.

Sources: home's investigation notes, home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 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 failed to ensure that staff used safe transferring and positioning techniques, as indicated in the resident's care plan, when assisting a resident.

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

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a skin assessment was completed when staff reported a resident's alteration of skin integrity of unknown origin.

Sources: resident's clinical records, the home's investigation notes, the home's policy, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

1- The licensee failed to perform weekly wound reassessments and monitoring of the wound and bruising of a resident.

Source: Clinical records of the resident, and an Interview with staff.

2- The licensee failed to perform weekly wound reassessments and monitoring of the wound of a resident.

Sources: Clinical records of the resident, and an Interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #011 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 for managing a resident's responsive behaviours were fully implemented.

Sources: Clinical records resident, home's policy.

WRITTEN NOTIFICATION: Responsive behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessments, reassessments, and interventions, and that the resident's responses to interventions were documented.

Sources: The resident's data collection tool and interview with the staff.

WRITTEN NOTIFICATION: Recreational and social activities program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)
Recreational and social activities program
s. 71 (2) Every licensee of a long-term care home shall ensure that the program includes,
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;

The licensee failed to ensure that programming activities were consistently offered to

residents of a Unit during days, evenings, and weekends.

Sources: Observations, the monthly activities calendar, interviews with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to ensure that shared equipment used to transport residents was clean and sanitary.

Source: Home's investigation notes, interview with staff, home's policy.

WRITTEN NOTIFICATION: Notification re incidents

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

1- The licensee failed to ensure that a resident's Substitute Decision Maker (SDM) was immediately notified of an allegation or suspicion of abuse or neglect, when a skin integrity alteration of unknown origin was discovered on a specified date.

Sources: resident's clinical records, the home's policy, and interviews with staff.

2- The licensee failed to ensure that the SDM of a resident was immediately notified of a witnessed resident-to-resident abuse incident.

Sources: The home's policy and interviews with staff.

WRITTEN NOTIFICATION: Police notification

NC #016 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 failed to ensure that the appropriate police force was immediately notified of a witnessed resident-to-resident abuse incident.

Sources: The home's policy and interviews with staff.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.Educate all Personal Support workers (PSWs) on the Aspen and Maple Units and All Activity Staff and the BSO team on the LTCH Policy to promote zero tolerance.
2.Keep a documented record of the education, including the content of the education,

the staff member who provided the education, date, and the names of staff who participated in the education.

Grounds

1- The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents when a resident struck a co-resident, unprovoked, resulting in injury.

A critical incident report was submitted regarding an alleged resident-to-resident physical abuse, resulting in injury that required hospital transfer.

Section 2. (1) (c) 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.

Failure to comply with the Long-Term Care Home (LTCH) zero-tolerance policy resulted in an increased risk of injury to a resident.

Sources: Clinical records for residents and interview with staff, the home’s policy.

2- The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents when a resident stuck a co-resident, unprovoked, resulting in injury.

Section 2. (1) (c) 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.

Sources: Clinical records for residents and the home’s policy.

3- The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents when a resident struck a co-resident, unprovoked, resulting in injury.

Section 2. (1) (c) 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.

Sources: Clinical records for the residents, interview with staff, the home’s policy.

4- The licensee failed to ensure compliance with the home's written policy to promote zero tolerance of abuse and neglect when a resident alleged that a staff member physically abused them. The home's investigation confirmed the abuse as founded.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

Sources: The home's investigation notes, the home's policy, and interview with staff.

This order must be complied with by December 17, 2025.

COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1-Complete an interdisciplinary review of the plans of care for the identified residents (Residents #004, #005, #006, #020, #022 and #023) and develop a Behaviour Support Plan for each resident that: Identifies responsive behaviour triggers and includes individualized interventions to minimize altercations and reduce potentially harmful interactions. The Behaviour support plan should incorporate activities, pharmacological interventions, and safety measures as appropriate.

2-Review the revised care plans, triggers, and interventions at weekly BSO huddles for four consecutive weeks to trial interventions and evaluate their effectiveness. When interventions are not effective, update and revise the plan of care and implement new strategies promptly.

3- At the conclusion of the each weekly BSO huddle, update the plan of care for each identified resident to reflect the effective, ongoing interventions that minimize the risk of

altercations and ensure staff are informed of the changes.

4. Keep a documented record of the interdisciplinary care plan reviews and BSO huddles including the date and time they occurred, staff name and designation who attended and a copy of the revised care plans for each identified resident.

Grounds
1- The licensee failed to ensure that steps were taken to minimize the risk of potentially harmful interactions between and among residents when they failed to implement the interventions identified for a resident's responsive behaviours.

The home's Responsive behaviour management policy directs that staff should be familiar with a resident's plan of care, the specific interventions for those behaviours, and be consistent with implementing those interventions. The plan of care for the resident identified them as having responsive behaviours towards other residents and identified interventions to be implemented.

Staff indicated that they were not aware of a resident's responsive behaviour history and acknowledged that, as a result, they did not implement their specified interventions. Failing to implement the identified interventions resulted in an incident of resident to resident abuse.

Sources: clinical health records, the home's policy, and interviews with staff.

2- The licensee failed to ensure that the interventions identified in the plan of care to minimize altercations were implemented resulting in an incident of resident to resident abuse.

The plans of care for a resident and co-resident identified interventions for the residents responsive behaviours. A critical incident report (CIR) was submitted related to a resident-to-resident altercation on a specified date. The CIR indicated that the identified interventions for both residents responsive behaviours were not in place at the time of the altercation between residents.

Staff indicated that at the time of the incident, it was a change of shift and acknowledged that the interventions for a resident had been effective but were not implemented at the time of the reported altercation, as staff were busy. During

observations conducted at the time of inspection at the home, on two specified dates, the identified interventions were not implemented.

Failing to ensure that interventions for the responsive behaviours for two co-residents were implemented resulted in an altercation between residents and posed an ongoing risk to residents.

Sources: The home's policy, residents' clinical health records, interviews with staff.

3- The licensee has failed to ensure that identified interventions were implemented to minimize the risk of altercations and potentially harmful interactions between two residents. Specifically, staff did not follow the individualized care plan strategies. This failure led to a physical altercation between the two residents, resulting in injuries to both.

Sources: The resident’s care plan and interview with staff.

4- The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents when three altercations took place on three separate dates in a specific resident area. A resident had a documented history of aggression toward co-residents. An intervention for the resident to minimize responsive behaviours was not in place.

Failing to ensure that the intervention was in place for the resident increased the risk of altercations with co-residents.

Sources: Interview with staff, clinical records for the resident, LTC home's documents.

This order must be complied with by January 16, 2026.

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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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:

Compliance Order from inspection number 2024-1193-0001, issued date 2024-05-08 for O. Reg. 246/22 s. 59 (b)

This is the first 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.