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: October 23, 2025

Inspection Number: 2025-1095-0006

Inspection Type:
Complaint
Follow up

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): October 16-17, and 20-23, 2025.

The following intakes were inspected:
- Intake: #00157939 was related to pain management; and,
- Intake: #00159346 - Follow-up to Compliance Order (CO) #001/2025-1095-0005; Fixing Long-Term Care Act (FLTCA), 2021 - s. 24 (1) Duty to protect, Compliance Due Date (CDD) October 15, 2025.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1095-0005 related to FLTCA, 2021, s. 24 (1).

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

Prevention of Abuse and Neglect
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was fully revised or updated when their care needs changed. The resident's care plan included a specific medication; however, that medication was discontinued a month earlier. When the home was alerted to the discrepancy, the care plan wording was immediately revised.

Sources: a resident's clinical records; and interview with the resident.

Date Remedy Implemented: October 16, 2025.

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with the home's pain management program when the effectiveness of a resident's pain management strategies were not documented as indicated in the home's pain management policy. In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for the pain management program were complied with. Specifically, the home's pain management policy specified that pain levels were to be assessed and the effectiveness of the PRN (as needed) medication documented one hour after administration. Multiple times, the documentation occurred over six hours after administration and, at times, after scheduled pain medication was administered.

Sources: a resident's clinical records, Pain Management; and interviews with the Nurse Practitioner (NP) and Director of Care (DOC).

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident received pain medication as ordered by the home's NP. On two separate days, registered staff did not follow the NP's directions when administering pain medication.

Sources: a resident's clinical records; and interview with the NP.