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: May 1, 2026
Inspection Number: 2026-1067-0003
Inspection Type: Critical Incident
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: Garden City Manor, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following dates): April 23, April 27-30, 2026 and May 1, 2026.

The following Critical Incident (CI) intakes were inspected:
- Intake #00171075/CI 2364-000020-26 was related to falls prevention and management; and
- Intake #00173508/CI 2364-000026-26 was related to falls prevention and management.

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

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

A resident was assessed by an interdisciplinary team member for use of an assistive device. However, the resident's plan of care was not fully updated with this recommendation regarding an identified activity of daily living (ADL).

On a later date, the resident was found after an unwitnessed fall when they were using a different assistive device than previously assessed. Staff acknowledged that directions were unclear as written for use of the assistive devices for supporting the ADL's of the resident.

Sources: Resident clinical records; interviews with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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.

The plan of care for a resident required that a device was to be provided to the resident for identified reasons.

On a date in March 2026, the resident was not provided with the specific device as required.

Sources: Resident clinical records; the home's internal investigation notes; interviews with staff; PSW Job description.