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

Toronto District
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Public Report

Report Issue Date: January 19, 2026
Inspection Number: 2025-1103-0006
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: Main Street Terrace, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 5-9, 13, 15-16, 19, 2026

The inspection occurred offsite on the following date(s): January 14, 2026

The following Critical Incident (CI) intakes were inspected:

· Intakes #00159765-CI #2589-000028-25 and #00163055-CI #2589-000030-25 were related to the prevention of abuse and neglect.

· Intake #00164665-CI #2589-000032-25 was related to fall prevention and management.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

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.

A resident stated that they felt insulted and intimidated by the manor in which a Personal Support Worker (PSW) spoke to them while providing them with care, on a specified date.

Sources: A resident's clinical records, home investigation notes, and interviews with a resident and other staff.

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 2 of Ontario Regulation (O. Reg.) 246/22 defines "physical abuse" as the use of physical force by a staff that causes physical injury to a resident.

A resident was not protected from abuse by a staff during and incident which resulted in the resident becoming injured and transferred to hospital.

Sources: Critical Incident Report, home's investigation notes; and interviews with PSW and other staff.

WRITTEN NOTIFICATION: Reporting certain matter to Director

NC #003 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.

Registered Practical Nurse (RPN) reported an alleged abuse of a resident to the Assistant Director of Care (ADOC) and Manager on call but they did not immediately report the information to the Director.

Sources: Critical Incident report, a resident's clinical records, home investigation notes, Interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 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.

A resident had two falls on a specified date, but only one post-fall assessment had been completed.

Sources: A resident's clinical records and interview with a ADOC.