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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: January 21, 2026

Inspection Number: 2026-1169-0001

Inspection Type:
Critical Incident
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: Westside, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 13-14, 16, 20-21, 2026
The inspection occurred offsite on the following date: January 15, 2026

The following intake was inspected in this Follow Up Inspection:
Intake: #00164717 - Compliance Order #001 from inspection #2025-1169-0006, O. Reg. 246/22, s. 53 (1) 1, Falls Prevention Program with compliance due date January 9, 2026

The following intake was inspected in this Critical Incident (CI) Inspection:
Intake: #00164116 -[CI: #2663-000039-25] - related to a fall with injury
Intake: #00164683 - [2663-000041-25] and Intake: #00166526 - [CI: #2663-000042-25] - related to outbreak management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1169-0006 related to O. Reg. 246/22, s. 53 (1) 1.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A Personal Support Worker (PSW) was observed on an outbreak unit entering two resident rooms on separate occasions to deliver meal trays for lunch and did not offer the residents hand hygiene. The PSW, a Registered Practical Nurse (RPN), and the IPAC Lead confirmed that hand hygiene should be offered to residents prior to meal service.

Sources: Observation, IPAC Standard for Long-Term Care Homes (Revised September 2023), and interviews with PSW, RPN and IPAC Lead.