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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: August 21, 2025
Inspection Number: 2025-1161-0003
Inspection Type: Complaint
Licensee: CVH (No. 3) 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: Chelsey Park, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
July 29, 30, and 31, 2025
August 1, 11, 12, 13, 14, 18, 20, and 21, 2025

The inspection occurred offsite on the following date(s):
August 11 and 15, 2025

The following intake was inspected:

- Intake: #00153405 - Complaint related to Resident Care and Support, Continence Care and Housekeeping

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management

Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Reporting and Complaints
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. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure that bathroom sinks, faucets and toilet areas were kept clean and sanitary.

Bathroom sinks, faucets and toilet areas were observed to have brownish-black grime on them, that was able to be removed. The Executive Director and Southbridge Clinical Consultant said that these areas were dirty, can be cleaner, and they were going to create a schedule to have them deep cleaned. On August 13, 2025, they were observed to have been cleaned with no grime present around the sink or the faucet as well as the other bathrooms were observed to be clean.

Sources: Observations in multiple rooms, interviews with the Executive Director and Southbridge Clinical Consultant.

Date Remedy Implemented: August 13, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

The resident's plan of care did not provide clear direction for different areas of care. The Assistant Director of Care verified the plan of care as not clear putting the resident at risk of not receiving the care required.

Sources: clinical record review of the resident's assessments, progress notes, plan of care, diagnoses, and other clinical data, observations of the resident and interviews with the resident's family member, and Assistant DOC and Interim DOC.

WRITTEN NOTIFICATION: Policy

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

Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act.

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with all applicable requirements under the Act.

The Southbridge Pain Management Program Policy last reviewed August 2025, documented to use the PAIN - Comprehensive Pain Assessment available in PointClickCare (PCC) to assess the resident in specific circumstances or extreme pain that can not be relieved using all available strategies (pharmacological and non-pharmacological).

The Quality Manager/Pain Lead verified the Pain Management Program Policy was the most recent updated version of the policy and verified the policy did not clearly identify the completion of a clinically appropriate instrument for the purpose of assessing pain when a resident's pain was not relieved by initial interventions. The Quality Manager understood that the regulation required the home to institute a policy under for the Pain Management program and verified the policy was not in compliance with all applicable requirements under the Act related to the Pain Management program set out in O. Reg. 246/22, s. 57 (2).

Sources: review of the clinical record for the resident and the Pain Management Program Policy RFC-03-21, and an interview with the Quality Manager/Pain Lead.

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
1. Review skin and wound management policy including assessment tools to be utilized. Keep a record of review, who participated, and date. Revise policy and assessments as required, as identified in the review completed. Keep a record of changes made.

2. Update the resident's plan of care to include clear and specific direction for staff

and communicate all new interventions to direct care staff.

3. Provide training to registered nursing staff on second floor and keep a record of the training, including content, who provided the training and who attended on what dates.

4. Provide training to personal support workers on second floor and keep a record of the training, including content, who provided the training and who attended on what dates.

Grounds
The licensee has failed to ensure that the resident received assessments, treatments and interventions as required.

The care plan did not include any specific direction related to skin and wound management strategies individualized to the resident, including pain monitoring. Discussion with the Assistant Director of Care (ADOC) and the Skin and Wound Champion identified areas of concern related to the completion of assessments and treatments and the implementation of interventions that were still not included in the plan of care.

Sources: Observations of the resident, health record reviews including assessments, progress notes, medication and treatment administration, etc., and interviews with resident, resident's SDM, Interim Director of Care, Assistant Director of Care, Wound Care Champion, Registered Nurse, Registered Practical Nurses, Personal Support Worker, Quality Manager/Pain and Palliative Care Lead, RAI Coordinator and physician.

This order must be complied with by October 3, 2025

COMPLIANCE ORDER CO #002 Continence Care and Bowel Management

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 56 (2) (a)
Specifically, the licensee must:
a) Ensure there is a review of the clinically appropriate assessment instrument that is specifically designed for assessment of incontinence to ensure it includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. A documented record of the date of the review, who participated, the changes made, if required, and any follow up with the registered staff responsible for the completion of this assessment must be maintained.
b) Ensure the resident receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument

that is specifically designed for assessment of incontinence.
c) Ensure the resident has an individualized plan of care to promote and manage continence based on the clinically appropriate assessment and the resident's individual continence needs. Communicate all new interventions to direct care staff and maintain a documented record of the follow up and communication with the the staff responsible for the implementation of the continence care plan.
d) Ensure the continence plan of care for the resident is implemented.

Grounds

The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

There was no continence assessment completed since admission that identified whether the resident was currently incontinent but had the potential to be continent, the resident was not assessed as continent or incontinent of bladder as part of the continence status summary, with no identified toileting routine, type of incontinence, bowel pattern, or causal factors. The Interim Director of Care (DOC) and Assistant DOC verified the resident did not have a continence assessment completed in full since admission.

Sources: clinical record review of the resident's assessments, progress notes, plan of care, diagnoses, and other clinical data, observations of the resident and interviews with the resident's family member, the Clinical Consultant, the Interim DOC and Assistant DOC.

This order must be complied with by October 3, 2025

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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

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.