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
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Public Report

Report Issue Date: June 17, 2025
Inspection Number: 2025-1030-0004
Inspection Type: Complaint
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: Dover Cliffs, Port Dover

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4, 5, 11, 12, 16, 17, 2025.

The following intake(s) were inspected:

- Intake #00147060 was a complaint related to care concerns for a resident.

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

Resident Care and Support Services
Continence Care

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

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

A resident was prescribed a medication in March 2025 with a specific start and end date. The medication was administered as prescribed, however, progress notes after the final administration indicated to continue administering the medication. The Administrator confirmed that directions regarding the antibiotics were not clear to staff who provided direct care to the resident.

Sources: progress notes, eMAR, and interview with the Administrator.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 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 failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed medication by their physician in February 2025, which

was not administered until five days after the order was placed. There was a technical issue with the digital pen used for communicating orders to the the pharmacy, however, the home stated that this five day delay between ordering and treatment provision was not aligned with their process for medication administration.

Sources: progress notes, orders, the home's investigation notes, and interviews with the Director of Care and other staff.