

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: December 9, 2025
Inspection Number: 2025-1030-0006
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: Dover Cliffs, Port Dover

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 2-4, 8, 9, 2025.

The following intake(s) were inspected:

Intake: #00161403 - Critical Incident (CI) 1056-000012-25 - Fall of a resident

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Head Injury Routine policy and Fall

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Management policy which was part of the licensee's Falls Prevention and Management Program.

Review of home's policy "Falls Prevention and Management Program" indicated that if a fall where a head injury was suspected and/or witnessed, a head injury routine (HIR) was initiated and neuro vital signs were monitored for 72 hours. The policy indicated that the staff were to complete the assessment every hour for 4 hours, and then every 8 hours until 72 hours post the fall.

In October, 2025 a resident sustained an unwitnessed fall and was placed on HIR assessment. Documentation and interview with the Director of Care (DOC) and the Administrator confirmed that the HIR was not completed as per policy on two evening shifts in October, 2025.

Sources: The home's falls policy "Fall Prevention & Management", number RFC-07-01 (last revised February 2025); Clinical records for the resident and Interviews with the DOC and Administrator.

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

In October, 2025 a resident fell and sustained an injury. The resident had falls prevention interventions in place at the time of the fall, however, the equipment was not working at the time of the fall. This was confirmed during interviews with a Personal Support Worker (PSW) and the Administrator. The incident was added to the staff falls huddle and procedures were put in place for staff to the equipment before and at the end of the shift to ensure they are working. At the time of the fall, the procedures to ensure that the resident's falls prevention equipment was in good repair, was not developed or implemented.



**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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Sources: Critical Incident 1056-000012-25, Clinical records for the resident and
Interviews with the PSW, DOC, Administrator.