

**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:** April 1, 2026

**Inspection Number:** 2026-1222-0002

**Inspection Type:**

Critical Incident

**Licensee:** Kingsway Nursing Homes Limited

**Long Term Care Home and City:** Kingsway Lodge Nursing Home, St Marys

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 25, 27, 2026 and April 1, 2026.

The following intake(s) were inspected:

Intake: #00170441 - 2726-000003-26 - 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.**

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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.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injuries policy and Assessment-Falls Risk Program policy which was part of the licensee's Falls Prevention and Management Program.

Review of home's policies "Assessment-Falls Risk Program" and "Head Injury" indicated that a Head Injury Routine should be initiated for all unwitnessed falls and witnessed falls that have resulted in possible head injury.

a) The resident sustained an unwitnessed fall in December, 2025 and a Head Injury Routine (HIR) was not found to be completed.

b) The resident sustained unwitnessed falls in December, 2025 and January, 2026. Neurological observations were not completed for all required times as the resident was noted to be sleeping. The DOC confirmed that staff were to wake the resident to complete the HIR.

Review of the home policy "Assessment-Falls Risk Program" outlined that the physiotherapist would complete a post fall assessment and document in Point Click Care (PCC).

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In December, 2025 a resident sustained two falls and a post fall assessment was not found to be completed by the physiotherapist in a timely manner.

Sources: The home's falls policy "Assessment-Falls Risk Program" policy 03-03-10 and "Specific Procedure: Head Injuries" policy 09-01-23; Clinical records for the resident and Interview with the DOC. [156]