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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: November 19, 2025
Inspection Number: 2025-1121-0006
Inspection Type: Proactive Compliance Inspection
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: MacKenzie Place, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 10, 12, 13, and 17-19, 2025

The following intake(s) were inspected:
-An intake related to a Proactive Compliance Inspection

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon

which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The home recorded three complaints related to improper resident care, none of which were reported to the Director. A resident reported that their incontinence product was not changed. Another resident also raised a concern about their incontinence product. An additional resident reported that they did not receive assistance for personal care from a Personal Support Worker (PSW), as requested. The Executive Director (ED) confirmed that these incidents were not reported to the Director because they believed they understood the circumstances and the complaints were unsubstantiated.

Sources: Home complaint log and an interview with the ED.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

1. Instructions were present in a resident's plan of care related to the implementation and use of a falls prevention intervention. A staff member reported that the resident was expected to have a certain intervention, as per their plan of care. The resident's Substitute Decision Maker (SDM) also indicated that the resident was expected to have the intervention. The resident was observed without the intervention in place.

The home's Falls Prevention and Management Program Policy outlined that Registered staff will implement appropriate strategies to reduce the resident's risk of falling, as well as, to optimize functional status and address injury prevention.

Sources: Observation, Health Records for a resident, the home's Falls Prevention and Management Program Policy, and interviews with staff and a SDM.

2. Intervals for a Head Injury Routine (HIR) assessment were completed for a resident with the exception of the initial interval. The intervals that were completed did not accurately document the resident's diagnosis.

The home's Falls Prevention and Management Program policy outlined that Registered staff are to assess the resident following a fall, including neuro and vital signs, and must complete a Falls Head Injury Routine every hour for four hours, then every eight hours for 72 hours.

The Assistant Director of Care (ADOC) acknowledged that there was no documentation of the initial HIR interval in the resident's clinical record. They also indicated that there was a gap in relation to the accuracy of the HIR intervals completed, noting that staff should be completing the assessment with appropriate responses regarding the diagnosis of the resident.

Sources: Health Records for a resident, the home's Falls Prevention and Management Program Policy, and interview with the home's ADOC.

3. Intervals for a HIR assessment were completed for a resident, however, the intervals that were completed did not accurately document the resident's diagnosis.

The home's Falls Prevention and Management Program policy outlined that Registered staff are to assess the resident following a fall, including neuro and vital signs, and must complete a Falls HIR every hour for four hours, then every eight hours for 72 hours.

The ADOC acknowledged that there is a gap in relation to the accuracy of the HIR intervals completed for the resident, noting that staff should be completing the assessment with appropriate responses regarding the diagnosis of the resident.

Sources: Health Records for a resident, the home's Falls Prevention and Management Program Policy, and interview with the ADOC.

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