

**Inspection Report under the Long-Term Care Homes Act, 2007****Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**  
**Division des opérations relatives aux soins de longue durée**  
**Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 10, 2020	2020_738753_0029	021957-20	Critical Incident System

**Licensee/Titulaire de permis**

CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)  
766 Hespeler Road, Suite 301 Cambridge ON N3H 5L8

**Long-Term Care Home/Foyer de soins de longue durée**

Shelburne Long Term Care Home  
200 Robert Street Shelburne ON L9V 3S1

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

KATHERINE ADAMSKI (753)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 30 - December 2, 2020**

**The following Critical Incident System (CIS) intake was inspected during this CIS inspection:**

**Log #021957-20 related to fall prevention and management**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Residents, and Personal Support Workers (PSW).**

**The inspectors also observed resident and staff interactions, reviewed clinical health records, and other pertinent documents.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)  
1 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**

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**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**
**Legend**

WN – Written Notification  
 VPC – Voluntary Plan of Correction  
 DR – Director Referral  
 CO – Compliance Order  
 WAO – Work and Activity Order

**Légende**

WN – Avis écrit  
 VPC – Plan de redressement volontaire  
 DR – Aiguillage au directeur  
 CO – Ordre de conformité  
 WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.  
Plan of care****Specifically failed to comply with the following:****s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).****Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care related to fall prevention interventions was implemented for a resident.

A resident sustained an unwitnessed fall that resulted in a significant injury.

The resident was at high risk of falls and their plan of care directed staff to implement various fall prevention interventions.

Multiple observations conducted by inspector #753 showed that the resident did not have fall prevention interventions implemented as outlined in their plan of care. Staff stated that they were unaware that some of the interventions were required.

Fall prevention interventions were not implemented as outlined in the resident's plan of care, which put the resident at risk of another fall and significant injury.

Sources: CI report, observations of the resident, interviews with the DOC and other staff, the resident's electronic chart including Kardex and plan of care [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2)  
the licensee is hereby requested to prepare a written plan of correction for  
achieving compliance to ensure that the plan of care related to fall prevention  
interventions are implemented for resident #001, to be implemented voluntarily.***

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**Ministry of Long-Term  
Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère des Soins de longue  
durée**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Issued on this 14th day of December, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**