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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: June 20, 2025
Inspection Number: 2025-1819-0004
Inspection Type: Critical Incident
Licensee: CVH (No. 7) 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: Southbridge Kemptville, Kemptville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18, 19, and 20, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake 00148586 (CI 3060-000024-25) - Fall resulting in injury; and
- Intake 00149606 (CI 3060-000028-25 - Fall resulting in injury.

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

Falls Prevention and Management

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 direction to staff on the use of a falls prevention intervention at a specific time.

The resident's power of attorney (POA) requested a specific falls intervention be used for the resident at a specific time. The resident's written plan of care was not updated with the intervention and only some staff were aware of the need for it. Furthermore, the resident experienced a fall and the intervention was not in place.

Sources: resident care plan; progress notes written by a Registered Practical Nurse (RPN), Registered Nurse (RN), and Restorative Care Coordinator (RCC) #109; and audio recorded interview with RN #107, RPN #104, Personal Support Worker (PSW) #105, PSW #106, Director of Care (DOC) #101, and RCC #109.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised, when their was a change in their sleeping patterns.

For approximately one month, a resident exhibited a change in their sleeping patterns. The resident's plan of care was never reviewed or revised to reflect the new behaviour, and the resident subsequently experienced a fall, resulting in an injury.

Sources: resident care plan; resident kardex; progress notes written by an RPN and RN #107; and audio recorded interview with RN #107, RPN #104, PSW#105, PSW #106, DOC#101, and RCC #109.