

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: September 18, 2025

Inspection Number: 2025-1819-0005

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): September 12, 15, 16, 17, 18, 2025

The following intake(s) were inspected:

- Intake: #00153644-CIR 3060-000041-25-Alleged improper/incompetent care of a resident by a staff member.
- Intake: #00155209-CIR 3060-000045-25-Fall of a resident with injury and transfer to hospital.

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

Prevention of Abuse and Neglect Falls Prevention and Management

INSPECTION RESULTS



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WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan. A resident used a wheelchair for mobility and the plan of care noted that the wheelchair was to be left at the resident's bedside. On a specified date in August 2025, the wheelchair was not left at the bedside and the resident used a walker to ambulate and had a fall with injury.

Sources: Resident health records, Critical Incident Report (CIR), and an interview with a Registered Practical Nurse (RPN).