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

Original Public Report

Report Issue Date: September 10, 2024
Inspection Number: 2024-1035-0006
Inspection Type: Critical Incident Follow up
Licensee: CVH (No. 6) 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 Cornwall, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3, 4, 5, 6, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00116861 - Follow-up #: 1 - O. Reg. 246/22 - s. 80 (2) - related to hydration and nutrition.
- Intake: #00123545 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) - related to Infection Prevention and Control (IPAC).
- Intake: #00119482 - CI# 3063-000045-24 - written complaint related to positioning of a resident.
- Intake: #00122435 - CI# 3063-000051-24 - related to a fall which resulted in injury.
- Intake: #00124500 - CI# 3063-000054-24 - related to responsive behaviours.
- Intake: #00125175 - CI# 3063-000055-24 - related to responsive behaviours.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1035-0002 related to O. Reg. 246/22, s. 80 (2)

Order #001 from Inspection #2024-1035-0005 related to O. Reg. 246/22, s. 102 (2) (b)

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a

resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that the assessment and monitoring of the resident's restraint was documented. Specifically, there was missing Point of Care (POC) documentation on specific dates.

Sources: Resident's health records, interview with PSW, RPN and DOC

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