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
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Public Report

Report Issue Date: June 27, 2025

Inspection Number: 2025-1035-0005

Inspection Type:
Critical Incident

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): June 23 - 27, 2025.

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

- Intake 00147331 (CI 3063-000026-25) - Alleged neglect of a resident by staff;
- Intake 00149112 (CI 3063-000033-25) - Alleged neglect of a resident by staff;
- Intake 00150295 (CI 3063-000036-25) - Fall of a resident resulting in injury; and
- Intake 00150630 (CI 3063-000038-25) - Improper care of a resident resulting in choking.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 diet texture set out in the plan of care was provided to a resident, as specified in their plan of care. Specifically, on a date in June, 2025, a staff member did not confirm the resident's diet texture before the resident received food and gave them an item of incorrect diet texture, which resulted in the resident choking.

Sources: Resident #004's health care records, interview with Personal Support Worker (PSW) #113 and Director of Care (DOC) #101.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response to a verbal complaint that was submitted by the Substitute Decision Maker (SDM) for a resident included the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Sources: Interview with Director of Care #101, and RN #15, review of Policy-RFC-04-02-Compliant Reporting, Investigation, and Response created August 2024, resident #001's progress notes.