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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: June 10, 2025

Inspection Number: 2025-1833-0001

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 2) 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 Goderich, Goderich

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14-16, 20-23, 26-28, 2025 and June 2, 2025. The inspection occurred offsite on the following date(s): May 27, 2025

The following intake(s) were inspected:
- Intake: #00142392 -disease outbreak
- Intake: #00142479, #00146283, #00146455 -resident fall with injury
- Intake: #00144679 -complaint related to family council
- Intake: #00145618 -allegation of improper care of a resident
- Intake: #00146237 -complaint related to operation of the home

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration

Safe and Secure Home
Infection Prevention and Control
Reporting and Complaints
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure a written complaint related to the operation of the home was forwarded immediately to the Director. A written complaint was sent to the licensee outlining concerns related to the operation of the home.

Sources: interview with staff and complaint letter.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to report allegations to the Director of improper or incompetent treatment or care of residents when staff had reported care concerns.

Sources: interviews with staff

WRITTEN NOTIFICATION: Right to be a member

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (5)
Family Council
s. 65 (5) Subject to subsection (6), a family member of a resident or a person of importance to a resident is entitled to be a member of the Family Council of a long-term care home.

The licensee failed to permit a person of importance to a resident to be involved in the Family Council.

The home communicated to a member of family council that they were no longer eligible to participate because they were not a family member of a resident in the home.

Sources: Complaint intake, interviews with staff and resident.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to comply with the home's skin and wound program . In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure that written policies that deal with the initial skin assessments and reassessment when an altered skin integrity was discovered was to occur, must be complied with.

Sources: record review of a resident and interviews with staff, Wound Management Policy, RFC-06-02, created August 2024.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg.

246/22, s. 54 (1).

The licensee failed to ensure that the strategies to reduce or mitigate falls for a resident were implemented.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that there are strategies to reduce or mitigate falls and that they are complied with.

Sources: Critical incident report, a resident's clinical record review, Policy -Falls Prevention and Management (RFC-07-01), Interview with staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to comply with the home's process to ensure that food service workers and other staff assisting residents were aware of the residents' diets and that the diet texture was followed.

Sources: progress notes, care plan, home's investigation, interview with staff.

WRITTEN NOTIFICATION: Attending physician or RN (EC)

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 88 (2)
Attending physician or RN (EC)
s. 88 (2) The resident or the resident's substitute decision-maker may retain a physician or registered nurse in the extended class to perform the services required under subsection (1).

The licensee failed to ensure that residents or substitute decision-maker's were informed they could retain a physician or a registered nurse in the extended class when admitted to the home.

Sources: interview with staff, family member, review of clinical record of a resident.

WRITTEN NOTIFICATION: CMOH and MOH

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The Licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home. Specifically, the licensee did not follow the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

During an outbreak, daily high-touch surfaces were not documented as being

cleaned or disinfected at least twice per day.

Sources: Critical incident report, daily high-touch surface cleaning checklist, interview with staff.

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 3 (1) 19. iv. [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
The licensee shall prepare, submit and implement a plan to ensure the home is complying with FLTCA, 2021, s. 19 (3) (iv), resident' rights related to their personal health information within the meaning of the Personal Health Information Protection Act, 2004 (PHIPA) to be kept confidential in accordance with that Act.
The home may include consultation with the Information and Privacy Commissioner of Ontario, review of all applicable PHIPA legislation related to protecting resident's personal health information and the use of email to exchange personal health information.
The plan must include

(1) The type of retraining involved if required, including who will be responsible for the retraining if required and when it will be completed.
(2) The person(s) responsible for monitoring that PIPHA is being complied, the frequency of monitoring and how it will be documented.
(3) The person(s) responsible for taking action if monitoring demonstrates PHIPA is not complied with; and
Actions to address sustainability once the home has been successful in ensuring compliance with PIPHA.
(4) A plan to address training related to PIPHA and emailing of resident's personal health information and any applicable policies and procedures from the home.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The home failed to ensure that resident's personal health information was secure when Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A, (PHIPA) was not complied with.

The Information and Privacy Commissioner of Ontario, Fact Sheet, Communicating Personal Health Information by email, September 2016, outlined information that included custodians of personal health information were to take reasonable steps to protect personal health information against theft, loss and unauthorized use or disclosure. This requirement applied to any email communications involving this type of information. Steps included providing a notice in an email that the information received was confidential, with instructions to follow if an email was received in error. Written policies for sending and receiving personal health information by email were required to be in place. Policies were to address when, how and the purposes for which this information may be sent and received by email, as well as any conditions or restrictions on doing so. The policy should also set out what types of information may be sent and received by unencrypted email and the

circumstances in which the custodian would use unencrypted email. Privacy and security training was to be completed with staff and to include training on the policy and procedure for sending and receiving personal health information by email.

Sources: interviews with staff, Privacy Commissioner information officer, review of email correspondence, review of google workspace agreement.

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #002 Medical services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 16
Medical services
s. 16. Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home.
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

(1) Ensure there is an organized program of medical services that includes a written description of the program, including goals and objectives and relevant policies, procedures and protocols. The program should provide for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, specifically the Nurse Practitioner (NP).

(2) Have this document available in the home for inspector review.

Grounds

The licensee failed to ensure that there was an organized program of medical services for the home. The organized program must have a written description of

the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Sources: clinical record review of residents, interviews with residents, staff and family,

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #003 No interference by licensee

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 71 (a)

No interference by licensee

s. 71. A licensee of a long-term care home,

(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

(1) Ensure staff, review FLTCA, 2021, related to Family Council, the Council's role and powers.

(2) Review and revise the home's policies and procedures related to Family Council, if required to align with the FLTCA, 2021. 3.

(3) Consult with the Family Councils of Ontario related to the role of the Family Council in long term care homes, and how homes and Family Council's might build a strong working relationship.

(4) Ensure that all individuals deemed important to a resident, or a family member

of a resident are permitted to meet together as one Family Council

Grounds

The licensee interfered with the operation of the existing Family Council.

Staff from the home met with existing Family Council representatives and reviewed policies and procedures. They advised the Family Council they needed to select a new president who had a family member in the new home, the home could not provide information requested by the council, and instructed the council where they could and could not meet.

Staff at the home said they had not been aware there had been an active Family Council. They acknowledged being remiss in not checking to ensure the interim FC president was a person of importance to a resident in the home.

Sources: Complaint, emails/notes, Family council minutes, interviews with staff and pre-existing Family Council attendees

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #004 General requirements

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

(1) Provide training to the medical services team on the tool used to complete a resident physical admission assessment and expectations for completion.
(2) A record of this training must include attendance, date of completion, content and format of the training that was provided.
(3) Review documentation expectations of the home referencing best practice, and documentation policies and procedures of the home. Include review of Regulation 246/22. S. 34 (2). Specifically discuss documentation in the residents' clinical record related to any actions taken with respect to a resident and late entry documentation. This review must include all registered staff, including agency registered staff and physicians. Keep a copy of documents reviewed and date reviewed and name of staff that were provided this education.

Grounds

The home failed to ensure that any actions taken with respect to a resident under a program, including assessments and interventions were documented for residents.

Documentation of resident's assessments were found to be missing information and not be complete. Actions taken by staff were missing from resident's clinical records.

When the home did not ensure actions taken related to resident care were documented in their clinical record and assessment documentation was complete there was moderate risk and impact. Care was delayed for residents. Communication between health care providers was not available for review or to respond to in their clinical record.

Sources: clinical record review for residents, email correspondence, interview with staff.

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #005 Pain management

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

(1) Review and revise the home's pain management program to include when a comprehensive pain assessment should be completed when initial interventions have not been effective. Provide all registered staff with re-education on any revisions made to the program.

(2) Provide all registered staff with re-education regarding the appropriate timeframe for documenting the follow-up effectiveness after administering scheduled and PRN pain medications.

(3) Maintain a record of the revisions and education provided to staff, and ensure these records are available upon Inspector request.

Grounds

The licensee failed to follow the pain management program for residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that

written policies developed for the pain management program which include monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, the home's program requires staff to complete a comprehensive pain assessment upon resident readmission to the home from hospital, when breakthrough pain medication is used for three consecutive days, and when a new pain medication is started for 72-hours after the medication is initiated.

A) A resident fell and sustained an injury.

Staff did not document any comprehensive pain assessments for a resident. Their pain was not resolved.

Sources: Observations, EMAR, Care plan, Program Pain Management, interviews with staff and resident

B) A resident was readmitted, and a comprehensive pain assessment was not completed. The resident's pain was not followed up on.

Sources: Pain Management Policy (RFC-03-21), a resident's progress notes, eMAR and comprehensive pain assessments, Interview with staff.

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #006 Nutritional care and hydration programs

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)
Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(b) the identification of any risks related to nutritional care and dietary services and hydration;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

(1) Review and revise policies and procedures, if needed, to ensure that the Mealsuite tablets and PSW tablets are included as part of the preventative maintenance program.
(2) Review and revise policies and procedures as needed, related to food and nutrition risks and include clear direction to staff related to steps to take when tablets malfunction.
(3) Re-educate staff involved in meal service on all policies and procedures related to food and nutrition where Mealsuite tablets is to interface with PSW tablets, included steps to take when the system is malfunction. Maintain a record of content of the training, date of training and attendance onsite.
(4) Audit different mealtimes on all home areas to ensure that the procedures in place are being followed related to Mealsuite and PSW tablets interfacing, ensure the auditing includes discussing if there are any concerns identified. Auditing should be continued until the time the home determines the malfunction has been corrected.
(5) Maintain records related to the auditing which include name of person completing the audit, date, time, unit, any concerns identified, and any actions taken, if applicable.

Grounds

The licensee failed to ensure that the system the home used to identify any

nutritional risks for residents and order resident meal preferences was consistently operational and that staff were to use this and followed the home's procedures to mitigate risks for residents.

A resident was served the incorrect texture meal and required medical intervention.

Sources: Critical incident, observations of staff and PSW tablets use, care plan, emails, interviews with the staff.

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #007 Agreement with registered nurse in extended class

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 90
Agreement with registered nurse in extended class
s. 90. Where a written agreement between a licensee and a registered nurse in the extended class is required under subsection 88 (4), the agreement must provide for, at a minimum,
(a) the term of the agreement;
(b) the responsibilities of the licensee; and
(c) the responsibilities or duties of the registered nurse in the extended class, including,
(i) accountability to the Medical Director for meeting the home's policies, procedures and protocols for medical services,
(ii) provision of services,
(iii) informing the licensee of the name of the physician with whom the registered nurse in the extended class has a consultative relationship, and
(iv) provision of after-hours coverage and on-call coverage.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Ensure that were is a written agreement between the registered nurse in extended class currently working with Southbridge Goderich, dated and signed and available for inspector review. Ensure that the agreement includes all required components of Regulation 246/22. s. 90.

Grounds

The home failed to ensure that there was an agreement with a registered nurse in extended class (Nurse Practitioner, NP). The agreement should have included the terms of the agreement, the responsibilities of the licensee and NP, accountability to the Medical Director for policies, procedures and medical services protocols, provision of services, informing the licensee of the name of the physician with whom the NP had a consultative relationship and provision of after-hours and on-call coverage.

Sources: interviews with staff

This order must be complied with by August 18, 2025

COMPLIANCE ORDER CO #008 Dealing with complaints

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
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:
1. The complaint shall be investigated and resolved where possible, and a response

that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

(1) Ensure all managers directly responsible for supervision of resident care are provided education in relation to what may constitute an allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident and steps to be taken based on the home's investigation policies and procedures.
(2) This training should include review of the home's investigation process policy, FLTCA 2021, s. 28 (1) (1) and Reg. 245/22, s. 108
(3) A record of this training must be kept in the home and include the date and time training was provided, attendees and outline of the education content.

Grounds

The licensee failed to investigate verbal complaints related to care concerns towards residents.

Sources: review of clinical records for residents, home's complaint log, interviews with staff.

This order must be complied with by August 18, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.