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: July 22, 2025
Inspection Number: 2025-1833-0003
Inspection Type: Proactive Compliance Inspection
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): July 8, 9, 10, 11, 14, 15, 16, 17, 22, 2025
The inspection occurred offsite on the following date(s): July 11, 18, 2025
The following intake(s) were inspected:

- Intake: #00151906 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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 failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provide direct care to the resident.

A resident's diet order stated they were to receive a different diet texture compared to the diet texture identified in their care plan. The food texture being incorrect in their care plan could pose a risk of being served the incorrect diet texture.

Sources: The home's Nutrition Assessments policy (#DP-02-06, dated November 2024); resident's clinical records, including orders, progress notes, and care plan; and an interview with Regional Dietary Consultant.

WRITTEN NOTIFICATION: Required programs

NC #002 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 when they failed to complete physiotherapy/occupational therapy and wound care champion referrals, when they were assessed as required for a resident, related to an area of altered skin integrity.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies developed for their skin and wound program were complied with.

Specifically, the home failed to comply with their policy titled "Wound Management" (RFC-06-02) (created August 2024), which stated that referrals were to be made to physiotherapy, and occupational therapy and to members of the interdisciplinary Skin and Wound Team as required. An assessment documented that a referral to physiotherapy/occupational therapy was required, however, was never completed for the resident. An assessment determined that a referral was required to the Wound Care Champion, but the referral was never initiated.

The Skin and Wound Lead stated that staff should have initiated referrals to the Physiotherapist and Wound Care Champion, as per the assessments, but did not. As a result of the referrals not been initiated the resident had not been assessed by physiotherapy or the wound care lead, at the time of the inspection.

Sources: Clinical records for a resident including assessments, progress notes, care plan, the home's policy titled "Wound Management" (RFC-06-02) (Created August 2024), and interviews with the skin and wound care lead and other staff.

WRITTEN NOTIFICATION: Skin and Wound Interventions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection when they exhibited altered skin integrity.

A resident had areas of altered skin integrity identified and treatments and interventions were not put into place immediately.

Sources: Wound Management Policy (RFC-06-02) dated August 2024, a resident's clinical record including assessments, progress notes and plan of care and interview

with the Wound Care Champion.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with the home's nutritional care and hydration program, when they did not assess a resident at least quarterly.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies developed for their nutrition care and hydration program were complied with.

Specifically, the home failed to comply with their policy titled "Nutrition Assessments" (#DP-02-06) (November 2024), which stated that the Registered Dietitian will conduct quarterly nutrition assessments for all residents.

A resident had a no quarterly assessment completed when they should have been assessed by the Registered Dietitian.

Sources: The home's Nutrition Assessments policy (#DP-02-06, dated November

2024); resident's clinical records, including weights/vitals, assessments, and progress notes; and an interview with the Regional Dietary Consultant.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee has failed to comply with the home's height and weight monitoring policy, as part of the nutritional care and hydration program, when they did not weigh a resident at least monthly.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies developed for their nutrition care and hydration program were complied with.

Specifically, the home failed to comply with their policy titled "Height and Weight Monitoring" (#RFC-10-04) (dated August 2024), which stated that care staff and registered staff were to ensure residents were weighed at least once a month, and if the weight had a 2.5kg difference from the previous month, the resident must be re-weighed.

A resident had significant weight loss, the Registered Dietitian requested re-weighs, and no re-weighs were completed. The following month, the resident had no monthly weight completed.

Sources: The home's Height and Weight Monitoring policy (#RFC-10-04, dated August 2024); resident's clinical records, including weights and vitals, and progress notes; and an interview with the Regional Dietary Consultant.

COMPLIANCE ORDER CO #001 Weight changes

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 75
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status.

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

The licensee must:

1. a) Complete an interdisciplinary review of the home's process for completing weights and reweights, communication regarding weight loss with the Registered

Dietitian, and the completion of appropriate nutritional assessments. Keep a record of the review, when it occurred and who participated.
b) Revise the above process as needed to ensure there is clear direction for nursing and dietary staff in the monitoring of weights, weight loss, communication and applicable nutritional assessments. Keep a record of the revisions, the date they were made and who participated.
2. Provide training to all Personal Support Worker staff, Registered Practical Nursing and Registered Nursing staff on a specific home area, related to the above reviewed/revised process.
3. Ensure that three specified residents have current weights measured and appropriate nutritional assessments related to weights are completed, as per the above reviewed/revised process. Ensure that plans of care are updated related to the assessments completed for these residents.
4. Complete weekly audits of weights and reweighs completed, as well as nutritional assessments, for residents on a specified home area, to ensure that the home's reviewed/revised process is followed. Keep a record of the audits completed, the date, who completed, what deficiencies were identified and steps taken to rectify deficiencies. Audits are to be completed until the compliance order is complied by the Ministry of Long-Term Care.

Grounds

The licensee failed to ensure that residents with weight changes of 5 per cent of body weight, or more, over one month, 7.5 per cent of body weight, or more, over three months, and 10 per cent of body weight, or more, over 6 months, were assessed using an interdisciplinary approach.

A) A resident had significant weight loss over one month, three months, six months, and a significantly low Body Mass Index (BMI). The resident was not assessed

following the significant weight loss.

B) A second resident had significant weight loss over one month, and over three months. The resident was not assessed following the significant weight loss.

C) A third resident had significant weight loss over three months, and over six months. The resident was not assessed following the significant weight loss.

There was increased risk to the residents related to not having been assessed following a significant weight loss, as the residents could have additional weight loss and health concerns with no additional nutrition interventions implemented for the residents. Additionally, one of the residents had a significantly low BMI.

Sources: The home's Height and Weight Monitoring policy (#RFC-10-04, dated August 2024), and Nutrition Assessments Policy (#DP-02-06 dated November 2024); resident's clinical records, including weights and vitals, assessments and progress notes; and an interview with the Regional Dietary Consultant.

This order must be complied with by September 1, 2025

COMPLIANCE ORDER CO #002 Food production

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

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

The licensee must:

1. Review any and all policies related to food temperatures. Revise the policies to ensure upper and lower limits for hot and cold foods and fluids are identified, outlining temperatures at which food will not be served to residents, documentation required, and the steps that staff will take in the event a food or fluid item has exceeded the limit.
2. Train all Food Service Workers and any other staff responsible for measuring food and fluid temperatures on the revised policies. Keep a record of the training including the dates the training occurred, names of staff who attended, who provided the training and the content.
3. Complete weekly audits of food temperature documentation for food preparation as well as food service. Keep a record of the audits completed, dates, who completed, what deficiencies were identified, and steps taken to rectify deficiencies. Audits are to be completed until the compliance order is complied by the Ministry of Long-Term Care.

Grounds

The licensee failed to ensure that food in food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

During a lunch meal service, a cold food item was not placed on ice to maintain the temperature.

During a lunch meal service, no end point temperatures were taken in the kitchen, after the food was cooked and prepared, prior to going up to the servery.
During a lunch meal service, the point of service food temperatures of some cold food items were documented between 12 and 13 degrees Celsius, and another cold food item was documented as 50 degrees Celsius, above the safe food temperature for cold foods of 4 degrees Celsius or below. No follow up corrective actions were completed after the temperatures were taken.

During another lunch meal service, the point of service temperatures of some cold food items were documented between 10 and 16 degrees Celsius, above the safe food temperature for cold foods of 4 degrees Celsius or below. The temperatures of some hot food items were documented between 50 and 54 degrees Celsius, below the safe food temperature for hot foods of 60 degrees Celsius. No follow up corrective actions were completed after the temperatures were taken.

Sources: Food Temperature – Holding and Distribution Safety Requirements policy (# RFNC-04-01, revised June 2025); food temperature records; observations; and interviews with the Regional Food Service Manager and other staff.

This order must be complied with by September 1, 2025

COMPLIANCE ORDER CO #003 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

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

The licensee must:

1. Review the home's policy related to skin and wound assessments. Upon completion of the review update the policy, as needed. Keep a documented record of the review including who participated in the review, the date the review occurred, and any changes made to the policy.
2. Retrain all registered nursing staff on the the home's current/revised policy related to skin and wound assessments including which assessment to complete for different types of altered skin integrity. Keep a documented record of the attendees, materials covered, the date(s) the training occurred, and who provided the training.
3. Complete a weekly audit of skin and wound assessments completed for specified residents. Keep a documented record of the date the audits were completed, who completed the audits, any deficiencies noted, and any actions taken to address the deficiencies. The audits must continue until the order is complied.

Grounds

a) The licensee has failed to ensure that a resident was reassessed at least weekly

when they exhibited altered skin integrity.

The resident had multiple areas of altered skin integrity and weekly assessments were not completed, as scheduled on the electronic treatment administration record (eTAR), and as required, including all the necessary elements to assess the areas.

Sources: Wound Management Policy (RFC-06-02) dated August 2024, a resident's clinical record including assessments, eTAR, and interviews with a Registered Nurse (RN) and the Wound Care Champion.

b) The licensee has failed to ensure that a resident was reassessed at least weekly when they exhibited altered skin integrity.

A resident had multiple areas of altered skin integrity and weekly assessments were not completed, as scheduled, and as required.

Sources: Wound Management Policy (RFC-06-02) dated August 2024, a resident's clinical record including assessments, progress notes and interviews with an RN and the Wound Care Champion.

This order must be complied with by September 1, 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

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.