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
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: April 29, 2025

Inspection Number: 2025-1703-0002

Inspection Type:
Critical Incident
Follow up

Licensee: CVH (No. 3) 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 Owen Sound, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15-17, 22-29, 2025

The following intake(s) were inspected:

- Intake: #00139002/CI#3061-000007-25: related to falls prevention management.
- Intake: #00139854/CI#3061-000011-25: related to alleged abuse.
- Intake: #00139998/CI#3061-000013-25: related to improper transfer.
- Follow-up #: 1 - O. Reg. 246/22 - s. 74 (2) (d) - Nutrition and Hydration Program.
- Intake: #00143250/CI#3061-000017-25: related to falls prevention management.
- Intake: #00143707/CI#3061-000020-25: related to alleged abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1703-0001 related to O. Reg. 246/22, s. 74 (2) (d)

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.
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,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that a resident's rights were respected with regards to refusing consent to treatment. An RPN provided an treatment to a resident after the resident refused the treatment.

Sources: Interviews with PSW, RN and Executive Director, Investigation notes.

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) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

In accordance with FLTCA s.154 (3), the licensee is vicariously liable when a staff member has not complied with subsection 28 (1) of the FLTCA.

The licensee has failed to ensure that a suspected incident of staff-to-resident abuse was reported to the Director immediately. A resident reported to a PSW that staff had provided rough care resulting in a sore wrist. The PSW immediately reported this allegation to an RPN. The RPN did not report this to the RN until 2 days later. The suspected incident was not reported to the Director until 2 days after the suspected incident occurred.

Sources: Interviews with Executive Director and PSW, Investigation interviews, After Hours Report.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

A nurse's aide transferred a resident in a manner that was not aligned with their plan of care for transfers.

Sources: Record review of resident's Care Plan, home's investigation notes, "Resident Lift and Transfers Policy", and interviews with the ED and nurse's aide.