

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 East District

33 King Street West, 4th Floor Oshawa, ON, L1H 1A1 Telephone: (844) 231-5702

Public Report

Report Issue Date: October 16, 2025 Inspection Number: 2025-1134-0005

Inspection Type:Critical Incident

Licensee: CVH (NO. 11) 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: Fosterbrooke, Newcastle

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 14-16, 2025.

The following intake(s) were inspected: -one intake regarding a fall with injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 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 has failed to ensure the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring



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of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Review of the resident's plan of care indicated they were a high risk for falls with multiple interventions in place. When the resident fell, the assistive device was not working. The homes falls and prevention program policy indicated that staff are to inspect assistive devices on each shift and complete hourly checks of those identified as a high risk for falls. Staff confirmed hourly checks were not completed for the resident.

Sources: Review of the resident's plan of care, the homes Falls prevention and management policy and interview with staff.



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