Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Mar 12, 2018	2018_682549_0007	003217-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

The Palace
92 Centre Street ALEXANDRIA ON K0C 1A0

Name of Inspector(s)/Nom de l’inspecteur ou des inspecteurs

RENA BOWEN (549)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 20, 21, 22, 23, 2018

During the course of the inspection, the inspector(s) spoke with residents, a family member, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC) and the Director of Care (DOC).

The inspector reviewed resident health care records, the licensee's Zero Tolerance of Resident Abuse and Neglect Program last updated April 2017, staff training documentation, continence care documentation, palliative orders, observed staff to resident and resident to resident interactions and the provision of care being provided to residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect 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 occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Health and Long Term Care received a complaint on a specific date in 2018 informing the Director that on a specific date in 2017, Registered Nurse (RN) #100 observed discolouration on a specific part of resident #001's body. RN #100 stated that when the PSW was asked about the discolouration on the noted dates, the PSW indicated that the discolouration was caused by the resident hitting an object. RN #100 stated that it was impossible due to the placement of the discolouration. RN#100 also stated that later the same PSW was witnessed by RN#100 forcefully grabbing the resident in the same manner.

Resident #001 was admitted to the home on a specific date in 2012 with multiple diagnoses. Inspector #549 reviewed the resident's progress notes for a specified time period in 2017 and 2018. The progress notes indicated that the resident had some behaviours and would resist care at times.

On February 20, 2018 during an interview the Director of Care (DOC) stated to Inspector #549 that the first time the licensee became aware of RN #100's suspicions of abuse of

resident #001 by PSW #101 was when the DOC requested an unrelated meeting with RN #100 on a specific date in 2018.

The DOC also stated that there is documentation in the resident's progress notes related to the discolouration on resident #001's on a specific date in 2017, there was no concern voiced or documented that there was a suspicion of abuse of resident #001. The DOC stated to the inspector that an investigation was completed after being notified on a specific date in 2018 and concluded that the alleged abuse of resident #001 did not occur.

During a telephone conversation with RN#100 on February 14, 2018 it was stated to the inspector that the alleged physical abuse of resident #001 by PSW #101 occurred either on one specific date or another specific date in 2017. RN #100 who was the Charge RN on both stated dates also stated that the suspected abuse was not reported to the Director of Care due to feeling intimidated after a previous complaint to the DOC about the same PSW's work routine was made.

The DOC stated to Inspector #549 on February 20, 2018 that the licensee became aware that the Director was informed of the suspected abuse of resident #001 on one of the specified dates in 2017 when Inspector #549 initiated the complaint inspection at the home.

As such, the licensee failed to ensure that any person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director when on one of the specified dates in 2017, RN #100 did not immediately report the suspected abuse of resident #001. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect 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 occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 12th day of March, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.