Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: November 22, 2024
Inspection Number: 2024-1150-0006
Inspection Type: Critical Incident
Licensee: CVH (No. 6) 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: The Palace, Alexandria

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18-22, 2024.

The following Critical Incident (CI) intakes were inspected:

Intake: #00129852 - CI 2642-000023-24 related to hospitalization with change in condition of a resident.
Intake: #00129859 - CI 2642-000024-24 related to a concern for care and support services of a resident.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), specifically related to the use of personal protective equipment (PPE) as is required by Additional Requirement 9.1 under the IPAC Standard, specifically at minimum Routine Practices shall include: e) Use of controls, including: i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

A staff member was observed to not disinfect the shared transferring device used for several residents and reported they were not required to sanitize the device unless they were on precautions. During a different observation another staff member was observed to not disinfect the device after use, and reported they sanitize the device once care is all done on the unit before the next meal.

Sources: Observations and interviews with staff members.