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

Ottawa District
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Public Report

Report Issue Date: June 27, 2025

Inspection Number: 2025-1150-0003

Inspection Type:
Complaint
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): June 23, 24, 25, 26, 27, 2025

The following intake(s) were inspected:

- Intake: #00146452 (CIS #2642-000018-25) related to alleged resident to resident abuse.
- Intake: #00147981 (CIS #2642-000019-25) related to alleged improper / Incompetent care of a resident.
- Intake: #00149095 (CIS #2642-000020-25) related to alleged abuse of a resident by a staff member.
- Intake: #00149020 - related to a complaint with multiple care concerns

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

Resident Care and Support Services
Skin and Wound Prevention and 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 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the treatment plan outlined in the plan was not effective.

A resident's skin assessment identified a specified altered skin integrity. A review of the electronic treatment administration record (eTAR) revealed that treatments were not consistently provided as outlined in the care plan.
The resident reported that treatments were only administered occasionally. A staff member stated that the resident often refused treatment.

Sources: Skin and wound assessment records, progress notes, Physician order, eTAR, and plan of care. Interview with staff members.

WRITTEN NOTIFICATION: Laundry services program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee has failed to ensure that the written description of the organized laundry services program included methods to reduce risk.

Staff are required to place residents' clothes and linen in colour coded bags daily before sending them to the laundry.
During this process, a resident's belonging was inadvertently left in a clothing's pocket and subsequently damaged after being sent to the laundry. Similarly, a second resident's valuable belonging, was also left in a pants pocket and laundered.
Interviews with a staff members stated that best practice would be to check and empty all clothing pockets prior to laundering.

Sources: Inspector's observation. Interview with staff members.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for each resident exhibiting responsive behaviours, the resident's responses to implemented interventions were consistently documented.

The resident's plan of care for identified responsive behaviours included one-on-one staff support and behaviours mapping to assess the effectiveness of the implemented interventions.

A review of the Dementia Observation System (DOS) charting revealed inconsistencies in the documentation of the resident's observed behaviours and responses to interventions.

Sources: Progress notes, Outpatient Progress Report, plan of care, and DOS charting. Interview with staff member.