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: August 1, 2025

Inspection Number: 2025-1150-0004

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): July 29-31, 2025 and August 1, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00151220/CI #2642-000022-25 related to a resident fall with injury
- Intake: #00152659/CI #2642-000023-25 related to an alleged resident neglect
- Intake: #00153033/CI#2642-000024-25 related to a resident fall with injury

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

Resident Care and Support Services
Falls 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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided a specific intervention as instructed in their plan of care.
On a particular day, the resident was observed without this specific intervention in place.
During an interview, the Director of Care (DOC) acknowledged that the resident's plan of care clearly identified the required intervention to address the resident's assessed needs.

Sources: Inspector's observation, resident's plan of care, interview with the DOC.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have

convenient and immediate access to it.

The licensee has failed to ensure that staff who provide direct care to a resident were kept aware of the content of the resident's plan of care.
A Personal Support Worker (PSW) stated in an interview , that they had not been made aware of the resident's fall resulting in an injury, therefore had not followed their plan of care. The Director of Care (DOC) indicated during an interview, that all staff were to be informed of all changes in the resident's condition and were to follow the updated plan of care.

Sources: Inspector observations, staff interviews, resident's plan of care.