Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 8, 2019	2019_730593_0031	014034-19, 014999-19, 015460-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 30, October 1 - 4, 2019.

CIS Log #014034-19 (2642-000009-19) was inspected related to a staff to resident alleged physical abuse.
CIS Log #015460-19 (2642-000011-19) was inspected related to a missing controlled substance.
CIS Log #014999-19 (2642-000010-19) was inspected related to an incident causing an injury to a resident for which the resident was taken to hospital and resulted in a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff (RNs), Personal Support Workers (PSWs), administration staff and residents.

The inspector observed the provision of care and services to residents, medication storage practices, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records and licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was based on,

at a minimum, interdisciplinary assessment of risk of falls with respect to the resident.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC) reporting an incident that caused an injury to resident #002 for which they were taken to hospital and resulted in a significant change in condition. It was reported in the CIS that resident #002 sustained a fall, resulting in a fracture. Resident #002 returned to the home with an assistive device for fracture stability and a change in ambulation status.

A review of resident #002's progress notes, found a history of falls prior to the CIS:

Resident #002 sustained a fall outside of the home. Resident #002 lost their balance and sat on the ground. No injuries sustained. Universal fall precautions in place.

Resident #002 fell outside, resident states that they stepped off the sidewalk and fell in the snow. No injuries sustained.

A review of completed e-Assessments for resident #002, found the following:

March, 2019- Falls Management- Scott Fall Risk Screen. Quarterly: High risk for falls 11.0.
May, 2019- Falls Management- Scott Fall Risk Screen. Quarterly: High risk for falls 11.0.
August, 2019- Falls Management- Scott Fall Risk Screen. Quarterly: High risk for falls 11.0.

A review of resident #002's plan of care found the following:

May, 2019- No focus, goals or interventions to address high falls risk.

August, 2019-

Focus: high Fall risk: failure to use assistive devices, limitations with mobility, poor balance.
Goals: resident #002's Scott fall risk will decrease to low.
Interventions: fall prevention interventions specific to resident: bed and chair alarm, one staff assistance for transfers, not allowed to walk unless with PT/PTA, not allowed to go outside.

During an interview with Inspector #593, October 3, 2019, ADOC #101 indicated that the

documented plan of care dated May, 2019 did not address risk of falls and was not included in the documented plan of care until August, 2019, after the fall, resulting in a significant change in condition.

Resident #002 sustained two falls in 2019 prior to the CIS. Resident #002 was assessed as high falls risk in March, 2019 however a documented plan of care to address risk of falls was not developed until August, 2019. As such, the licensee has failed to ensure that the plan of care for resident #001 was based on, at a minimum, interdisciplinary assessment of risk of falls with respect to the resident. [s. 26. (3) 10.]

Issued on this 10th day of October, 2019

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

Original report signed by the inspector.