Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Dec 3, 2020	2020_785732_0028	003239-20, 004043-20, 011876-20, 021320-20	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

EMILY PRIOR (732)

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): November 20, 23 - 26, and 30, 2020; and December 1, 2020.

The following intakes were inspected during this Critical Incident System inspection:

Log #004043-20 (Critical Incident Report (CIR) #2642-000006-20) and log #011876-20 (CIR #2642-000009-20) related to alleged resident to resident abuse and responsive behaviours.

Log #003239-20 (CIR #2642-000004-20) and log #021320-20 (CIR #2642-000016-20) related to alleged staff to resident abuse.

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

The inspector(s) reviewed resident health care records, relevant investigation records, and relevant policies; as well as observed the provision of care and services to residents, staff to resident interactions, and resident to resident interactions.

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

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents were protected from abuse by a PSW

A PSW witnessed an incident of verbal abuse by another PSW to a resident around 0700 hours. The witnessing PSW told Inspector #732 that they reported the incident to the ADOC within an hour or two, but did not report immediately. Investigation notes indicated that there was another incident of verbal abuse involving the same PSW that morning; this time with a different resident at around 0725 hours. As the alleged verbal abuse was not reported immediately, the PSW continued to provide care to residents after the incident at 0700 hours, and subsequently the other incident of verbal abuse occurred, around 25 minutes later. Management was not made aware of either incident until 0835 hours that morning.

Furthermore, the alleged PSW continued to work the remainder of their shift, providing care to other residents while the investigation was being completed; with instructions to not be in contact with the above mentioned two residents. The PSW met with management at the end of their shift and was disciplined with a two day suspension occurring on their next two shifts. The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences", describes that in cases where the allegation of abuse or neglect is made against an employee, management will immediately advise the employee that they are being removed from the work schedule, with pay, pending investigation. The ADOC confirmed that normal practice is to send a staff member home pending investigation when there is an allegation of abuse against them. By allowing the accused PSW to work the remainder of their shift that day, the two residents mentioned above, and all other residents were at risk of further abuse.

Sources: Interviews with ADOC, PSW, and other staff; investigation notes related to incident; Critical Incident Report; inquiry for Critical Incident Report; Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy. [s. 19. (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 residents are protected from abuse by anyone and shall ensure residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 3rd day of December, 2020

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

Original report signed by the inspector.