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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 4, 2024	
Inspection Number: 2024-1150-0002	
Inspection Type: Complaint	
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	
Lead Inspector Heath Heffernan (622)	Inspector Digital Signature
Additional Inspector(s) Mark McGill (733) Kelly Boisclair-Buffam (000724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 - 10, 14 - 17, 21, 22, 2024.

The following intake(s) were inspected:

- Complaint Intake: #00111875 - related to resident care and services, infection prevention and control and falls prevention and management.
- Complaint Intake: #00114112 - related to resident care and services.

The following Inspection Protocols were used during this inspection:

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Residents' Rights and Choices
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident's sleep and rest plan of care, sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
Review of the most recent care plan and kardex documents on point click care indicated that the resident preferred to get up at a specified time in the morning.

Review of the Personal Support Worker/Resident Assignment documents indicated

that the time staff were assigned to get the resident up, did not match the resident's choice on their sleep and rest care plan and kardex.

During an interview with Inspector #622 on a date in May 2024, the resident stated that staff were getting them up each morning at a time other than the specified time on the care plan and kardex.

By not providing clear direction within the resident's sleep and rest plan of care, the resident was provided care that was contrary to their assessed needs and wishes.

Sources: Review of the resident's care plan and kardex documents, and interview with the resident.
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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of resident's bowel management patterns were documented.

Rationale and Summary:
A review of a resident's plan of care, Bowel Binder form, Medication Administration Record (MAR) and Documentation Survey Report in Point of Care (POC) was completed.
The plan of care identified that the resident had interventions in place for their

continence management program. The resident's MAR showed that the resident had multiple pharmaceutical interventions being utilized.
An evaluation of the Documentation Survey Report in Point of Care (POC) was conducted for a three month period in 2024, which indicated twenty four missed entries under Elimination, Continence and Toileting.

- A further review of the licensee's Continence Management Program Policy # RC-14-01-01 , page 3 of 5- #6, stated that all care staff are to complete all relevant and required documentation.

On March 21, 2024, interviews with a Registered Nurse (RN), a Personal Support Worker (PSW) and the Director of Care (DOC), confirmed that the expectation was for PSWs to fully complete their POC documentation for elimination and continence patterns for the resident. The DOC also confirmed that the PSWs were expected to document in the POC as per the licensee's Continence Management Program and acknowledged the multiple missed entries found. A discussion with a PSW on March 22, 2024, had also confirmed the expectation of completing all POC documentation for the resident's elimination patterns.

As such, failing to complete the documentation under Elimination, Continence and Toileting in POC for the resident, potentially increased the risk of the resident suffering from severe constipation or diarrhea.

Sources: The resident's plan of care, Elimination, Continence and Toileting POC documentation and MAR, licensee's Policy for Continence Management Program RC-14-01-01, interviews with an RN, PSWs and the DOC. [000724]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

1) The licensee has failed to comply with the Falls Prevention and Management Program's procedure to inspect and remove any mechanical lift slings with identified deficiencies prior to use.

In accordance with O. Reg 246/22, s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

Specifically, staff did not comply with the licensee's policy #RFC-02-13, titled: Resident Lifts and transfers, Created: April 2024, and the Visual Sling Inspection Guidelines.

Rationale and Summary

Review of the licensee's policy #RFC-02-13, titled: Resident Lifts and transfers Policy Created April 2024, indicated that the mechanical lift slings need to be inspected by the PSW prior to each use.

Review of the Visual Sling Inspection Guideline indicated that mechanical lift slings were to be checked for illegible or missing labels. Blank or missing labels indicated frequent use and laundering and may also indicate exposure to bleach. Without a legible label, the safe working load of the mechanical lift sling could not be identified. If any deficiencies are identified or suspected, remove the mechanical lift sling from service and deliver it to the supervisor.

On May 17, 2024, Inspector #622 observed two mechanical lift slings on second floor; one without a label and the other had a label that was illegible, both lift slings were in circulation for use.

During an interview with Inspector #622 on May 17, 2024, a Personal Support Worker (PSW) stated that they had observed mechanical lift slings that had issues with the labels being worn or were unable to be read that had not been removed from service.

During an interview with Inspector #622 on May 21, 2024, Activation Aide/Project Supervisor over mechanical lift sling audits and tracking stated that if a mechanical lift sling's label was missing or could not be read, the sling should be removed from circulation and replaced.

By not following procedures to monitor the condition of mechanical lift slings and the removal of any mechanical lift slings with identified deficiencies, increased the risk for falls and injury of residents during transfers with mechanical lifts.

Sources: Review of the licensee's Policy #RFC-02-13; the Visual Sling Inspection Guideline; observation of mechanical lift sling condition; interview of a PSW and other staff.
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2) The licensee has failed to comply with the Falls Prevention and Management Program's procedure to ensure that all wheelchairs have the brakes applied when not in use.

In accordance with O. Reg 246/22 s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

Specifically, staff did not comply with the licensee's policy: RC-15-01-01 - Falls Prevention and Management dated reviewed March 2023.

Rationale and Summary
Review of the licensee's policy: RC-15-01-01 - Falls Prevention and Management, reviewed March 2023, indicated that specific Universal Falls Precautions were to be used and implemented for all residents including the use of wheelchair brakes.

On May 14 and 15, 2024, Inspector #622 observed multiple wheelchairs that were not in use, parked along the left side of the second-floor hallway with the brakes in the off position. There were residents wandering in the hallway past the wheelchairs during each observation.

During an interview with Inspector #622 on May 15, 2024, a Registered Nurse (RN) acknowledged that according to the fall prevention program, brakes should always be applied to wheelchairs when they are not in use.

By not following procedures to ensure that brakes have been applied to wheelchairs that are not in use, increased the risk for falls and injury to the residents.

Sources: Review of the licensee's policy: RC-15-01-01, resident plans of care and observation of parked wheelchairs.
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WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The licensee has failed to ensure that housekeeping services were provided as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, where the licensee shall ensure that procedures were developed and implemented for the cleaning of a resident's washroom floor.

Rationale and Summary
During multiple observations on a date in May 2024, a resident's washroom floor had remained soiled for four hours.

During an interview with Inspector #622 on a date in May 2024, the Environmental Services Manager (ESM) stated that housekeeping procedure for cleaning the resident's washroom floor would include the scheduled daily cleaning, plus unwritten direction for the housekeepers to perform extra monitoring and cleaning throughout the day if they had time.

By not ensuring that the procedures for cleaning a resident's washroom floor was developed and implemented, increased the risk that the washroom floor would remain soiled.

Sources: Observations of a resident's washroom floor and interview with the ESM and other staff.
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