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: August 08, 2024
Inspection Number: 2024-1150-0003
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): July 22-25, 29-31, 2024 and August 1-2, 5-8, 2024.

The inspection occurred offsite on the following date(s): July 26, 2024, and August 2, 2024.

The following intake(s) were inspected:

- Intake: #00117222/ CI #2642-000006-24 - related to Rhinovirus outbreak declared May 2024
- Intake: #00118078/ CI #2642-000007-24 - related to medication administration
- Intake: #00119751/ CI #2642-000009-24 - related to fall of a resident that resulted in significant change
- Intake: #00122654/ CI #2642-000011-24 - related to alleged improper treatment of resident by staff

The following complaint intakes were inspected:

- Intake: #00114112 - related to care concerns of a resident
- Intake: #00117800 - related to alleged neglect of a resident by staff

The following Inspection Protocols were used during this inspection:

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Reporting and Complaints
Resident Care and Support Services
Restraints/Personal Assistance Services Devices (PASD) 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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for a resident.

Sources: Resident's electronic health records (EHR) and interview with DOC #100

WRITTEN NOTIFICATION: Restraining by physical devices

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 4.
Restraining by physical devices
s. 35 (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations ordered or approved the seatbelt restraint for a resident.

Sources: Resident's physical chart and EHR, interviews with ED #102 and other staff

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed within one business

day of an incident that caused an injury to a resident, for which the resident was taken to hospital and resulted in a significant change in their health condition.

Sources: Resident's EHR and interview with DOC #100

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.
Requirements relating to restraining by a physical device
s. 119 (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee has failed to ensure that the requirements are met with respect to restraining a resident by a physical device under section 35 of the Act, that staff apply the physical device in accordance with any manufacturer's instructions.

Sources: Critical incident #2642-000011-24, resident's EHR, Wheelchair User Instructional Manual, interviews with PSW #103 and other staff

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to comply with the home's medication management policy related to the implementation of medication administration process.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies, protocol and procedure of their medication management policy were complied with. Specifically, staff did not comply with the licensee's Medication Administration procedure policy #RC-16-01-07 revised March 2023.

Sources: Review of the home's medication management policy# RC-16-0-07 revised March 2023. Medication Administration Audits conducted by the home, interviews with DOC #100 and other staff.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that a medication cart was locked during a meal observation on two different units.

Sources: Inspector observations and interviews with RN #105 and other staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that medication administered to the residents were prescribed for the residents.

Sources: Review of home's internal investigation notes, e-mail correspondence from staff members to the home's administration, interviews with DOC #100, and other staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

1. The licensee has failed to ensure that residents are administered medication as

per their physician's orders and directions

Sources: Review of home's Electronic Medication Administration record (e-mar) evening medication pass audit, home's internal investigation notes, Medication Administration Audit conducted by the home, e-mail correspondence from staff members to the home's administration, interviews with DOC #100, and other staff

2. The licensee failed to ensure that drugs are administered to a resident in accordance with the directions for use specified by the prescriber. Specifically, the licensee failed to administer a medication to a resident on several occasions during a specified time as specified by the prescriber.

Sources: Resident's Electronic Medication Administration Records, interview with DOC #100