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: November 28, 2024
Inspection Number: 2024-1150-0007
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 from November 18-22, 2024.

- The following intake was inspected:
- Intake #00129359 regarding an allegation of staff to resident neglect.

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

Prevention of Abuse and Neglect

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 the care set out in the plan of care related to falls prevention and toileting was provided to a resident as specified in their plan.

On a specified date, a resident was left unattended by staff for an extended period of time, without the provision of care or any method to communicate with staff.

Sources: Resident health care record review and interviews with an RPN and the Director of Care.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's resident-staff communication and response system equipment was accessible to a resident at all times on a specified date. This resident required assistance over an extended period of time and did not have access to their communication and response system equipment, as it was out of reach.

Sources: Record review of resident health records and interview with a PSW, an RPN and the Director of Care.