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

Public Report

Report Issue Date: January 29, 2025

Inspection Number: 2025-1150-0001

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 on the following date(s): January 27, and 28, 2025

The inspection occurred offsite on the following date(s): January 29, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00136011 (CI #2642-000001-25) -Alleged improper/incompetent care of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee has failed to ensure that where a resident was restrained by a physical device under section 35 of the Act, that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The physician ordered a physical restraining device, as needed for restraint of a resident. Due to safety concerns, the resident was removed from that restraint and staff placed the resident in a different physical restraining device which had not been ordered or approved by the physician.

Sources: Resident #001's health care records; investigation notes; and interviews with ADOC #101, RN #102, RN #105, and PSW #104.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a

resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response is documented.

Specifically, while a resident was in a physical restraining device, there was no documentation of the required hourly safety checks for monitoring the resident's restraint use.

Sources: Resident #001's health care records; investigation notes; Minimizing Restraint Use Policy, Policy No. RFC-02-19, created August 2024; and interviews with ADOC #101, RN #102, RN #105, and PSW #104.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 7.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning.

The licensee has failed to ensure that every use of a physical device to restrain a

resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that every release of the device and all repositioning is documented.

Specifically, while a resident was in a physical restraining device, there was no documentation of the required two hourly position changes and release of the restraint.

Sources: Resident #001's health care records; investigation notes; Minimizing Restraint Use Policy, Policy No. RFC-02-19, created August 2024; and interviews with ADOC #101, RN #102, RN #105, and PSW #104.