

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

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Public Report

**Report Issue Date:** November 6, 2025

**Inspection Number:** 2025-1530-0007

**Inspection Type:**

Critical Incident  
Follow up

**Licensee:** Board of Management for the District of Parry Sound West

**Long Term Care Home and City:** Belvedere Heights, Parry Sound

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 27-31, 2025

The inspection occurred offsite on the following date(s): November 3, 2025

The following intake(s) were inspected:

- Three Intakes related to an allegation of Improper/incompetent care of residents by staff.
- One Intake related to follow up of CO #001 related to inspection # 2025-1530-0004, O. Reg. 246/22 - s. 58 (4).
- One Intake related to allegation of Neglect of a resident.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:  
Order #001 from Inspection #2025-1530-0004 related to O. Reg. 246/22, s. 58 (4)

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

Resident Care and Support Services  
Responsive Behaviours  
Prevention of Abuse and Neglect

## INSPECTION RESULTS

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## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 1.**

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A) On two specified dates a resident's rights related to dignity were not respected by staff.

**Sources:** Inspector observations; the home's investigation notes; and interviews with staff, and the DOC.

B) On a specified date a resident's rights related to dignity were not respected by staff.

**Sources:** The home's investigation notes; and interviews with staff, and the Director Of Care (DOC).

## WRITTEN NOTIFICATION: Care Plan

NC #002 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

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the resident as specified in the plan.

On an identified date, the staff failed to ensure that the specified intervention for a resident was provided.

**Sources:** A resident's electronic medical records and care plan; the home's investigation file; an interview with the Director of Care (DOC).

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A) On a specified date, a resident was provided with improper care. The home submitted the CI on the next day.

**Sources:** Critical Incident (CI); and an interview with the ADOC.

B) An incident of improper care towards resident's was reported by a staff member on a specified date to the ADOC , and was not reported to the Director by the home until two days later.

**Sources:** CI; the home's investigation notes; Review of the resident's clinical records; Review of the home's policy titled, "Prevention of Abuse and Neglect Zero Tolerance"; Review of the home's internal investigation notes; and an interview with the DOC.

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## WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)**

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A) On an identified date, the licensee became aware of an allegation of improper care for resident. The resident's Substitute Decision Maker (SDM) was not notified until many days later.

**Sources:** CI; a resident's progress notes and contacts for the resident; interview with the DOC.

B) On an identified date, the licensee became aware of an allegation of improper care for resident's. The resident's SDM was not notified until many days later.

**Sources:** CI; resident's progress notes; and SDM contacts for the resident's; interview with the DOC.

## COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 40**

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe

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transferring and positioning devices or techniques when assisting residents.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The license shall:

- A) Educate the identified staff on the safe lift and transfer process in the home, including mechanical lifting, bathing, and other transfer devices. Maintain a written record including the content of the education, the individual who provided the education, the date and time it was provided.
- B) Develop and implement a documented auditing process to ensure that the identified staff, perform transfers as per the home's established procedures and the resident's plan of care. For each of the identified PSWs, audits must be conducted on a minimum of five resident transfers, which are completed on different dates. For any deficiencies identified during the auditing process, corrective action must be taken and documentation of this corrective action must be maintained.

**Grounds**

- A) On a specified date, staff who were providing care to a resident, did not follow the home's policy or process when completing a transfer.

**Sources:** Assessments and plan of care for a resident; the home's investigation notes; the home's policy titled "Mechanical Lifting"; the home's policy titled "Bathing and Transfer Devices"; and, interviews with a resident; identified staff; and the DOC.

- B) On a specified date, staff performed an improper transfer of a resident.

**Sources:** Progress notes, assessments and plan of care for a resident; the home's investigation notes, the home's policy titled "Mechanical Lifting"; the home's policy titled "Bathing and Transfer Devices"; and, interviews with staff; and the ADOC.

**This order must be complied with by** November 28, 2025

**NOTICE OF RE-INSPECTION FEE**

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of \$500.00 to be paid within 30 days from the

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date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

This was the second follow-up to CO#001 from inspection 2025\_1530\_0004 that was inspected in intake #00157562.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

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