Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2014	2014_283544_0022	S-000253-14	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

Long-Term Care Home/Foyer de soins de longue durée

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 19, 20, 2014 in relation to:

Log # S-000253-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Associate Director of Care, Registered Staff, Personal Support Workers (PSWs), Residents and Families.

During the course of the inspection, the inspector(s) observed the delivery of care and services to the Residents, staff to Resident interactions and the posted Residents' Bill of Rights in the home, reviewed policies and procedures regarding Prevention of Abuse and Neglect, staff training/education records regarding the Policy of Prevention of Abuse and Neglect, Resident's health care records including progress notes, treatment administration records, bathing records, critical incident report and documentation related to the incident.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home reported a Critical Incident to the Director related to an allegation of staff to resident abuse.

Inspector # 544 reviewed the Critical Incident Report.

Inspector # 544 reviewed Resident # 001's health care record, progress notes, plan of care, treatment administration records, and the documentation provided by the home of their investigation into an allegation of staff to resident abuse. It was identified in the progress notes and the bathing records, that Resident # 001 would often refused baths or showers.

According to the critical incident report, Staff # 106 and Staff # 107 pulled Resident # 001's bed sheets away from them. Resident # 001 refused and pulled the sheets back up. Staff # 106 and Staff # 107 again pulled Resident # 001's bed sheets away and then Resident # 001 proceeded to get up into their wheelchair.
Resident # 001 told the Inspector that they did not like to get up too early, shower or bathe. They told the Inspector that they suffer from generalized pain most of the time and get anxious. Resident # 001 was cognitive and very articulate during the interview.

The home conducted an investigation and found that Staff # 106 and Staff # 107 were involved in the incident when Resident # 001 resisted care.
Staff # 106 and Staff # 107 were disciplined with a disciplinary written letter, related to this incident.
Further disciplinary actions included that Staff # 106 and Staff # 107 were required to review the home's Prevention of Abuse policy, complete the abuse quiz and re-read the Residents' Bill of Rights. Staff # 106 also submitted a plan of action to ensure that this type of incident would not occur again.

The above information was confirmed by Staff # 101 and Staff # 102.

The licensee did not ensure that Resident # 001's right to have their participation in decision-making respected. [s. 3. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure Resident # 001 has the right to have their participation in decision-making respected, to be implemented voluntarily.

Issued on this 8th day of September, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs