



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 12, 16, 17, 18, Sep 7, 2011	2011_057163_0011	Mandatory Reporting

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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), Associate Director of Care (ADOC), Nutrition Manager (NM), registered nursing staff, personal support workers (PSWs) and residents.

During the course of the inspection, the inspector(s) reviewed the licensee's Mandatory Report documentation and home's policies, observed staff to resident and resident to resident interactions, reviewed licensee's in-service training records and observed staff to resident care and services.

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Définitions

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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.**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits sayants :

1. The licensee has not ensured that incidents of abuse are immediately reported to the Director. Inspector reviewed a Mandatory Report. Documentation indicates that the Associate Director of Care (ADOC) was made aware of this alleged abuse incident in or about the month of May 2011, however the incident was not reported to the Ministry until June 20, 2011. [s.24(1)2]
2. Inspector reviewed an additional Mandatory Report. Documentation from this report indicates that the alleged abuse incident occurred on May 07, 2011 however it was not reported to the Ministry until May 16, 2011. [s.24(1)2]

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 with reporting to the Director abuse of a resident by anyone or neglect of a resident by the licensee, or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance
Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits sayants :

1. The licensee did not ensure that the home's policy PER 2300 "Prevention of Abuse and Neglect Zero Tolerance" was complied with as this policy indicates on page 5, #11 "Immediately notify police of any alleged, suspected or witnessed incident of abuse or neglect that may constitute a criminal offence". The inspector reviewed a Mandatory Report of an alleged incident of abuse by a staff member toward a resident. The appropriate police force was not contacted. Inspector interviewed the DOC on August 16, 2011 who confirmed that police were not contacted in this incident.
2. The inspector reviewed an additional Mandatory Report incident of abuse. The inspector interviewed the DOC on Aug 16/11 who reported "I don't believe the police were notified of this incident". The DOC added "I did not call the police, I should have according to our policy". The licensee did not ensure their home's policy was complied with.



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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 the home's policy to promote zero tolerance of abuse and neglect is complied with, in regards to "immediately notify police", to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits sayants :

1. The licensee failed to report to the Director the results of an investigation of a Mandatory Report incident. The report dated June 20/11 was reviewed with the DOC on Aug 16/11. The DOC reported "I did not report the results of this investigation".

Issued on this 15th day of September, 2011

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

Diana Jendund