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

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

Original Public Report

Report Issue Date: March 27, 2023	
Inspection Number: 2023-1530-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Board of Management for the District of Parry Sound West	
Long Term Care Home and City: Belvedere Heights, Parry Sound	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.03.28 11:16:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 14 -16, 2023.

The following intake(s) were completed in this inspection:

- Two intakes related to falls which resulted in injury;
- One intake of a complaint related to concerns with care of a resident;
- One intake related to abuse of a resident by a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 58 (3) (b)

The licensee has failed to ensure that the Responsive Behaviours program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home's policy titled, "Responsive Behaviours, Gentle Care Approach", was last updated, March 2013.

The home's Behaviour Support Lead acknowledged that the Responsive Behaviours Program should have been evaluated and updated annually; and had not been done.

At the time of the Inspection, the home's Responsive Behaviours Committee met, conducted an evaluation of the program, and updated the program in accordance with evidence-based and prevailing practices.

There was no impact and low risk to residents, when the home failed to ensure, that at least annually, the Responsive Behaviours program was evaluated and updated, as the home had various processes in place to support the management of responsive behaviours and resident to resident altercations in the home.

Sources: Home's policy titled, "Responsive Behaviours, Gentle Care Approach", effective date, March 2013; and interview with the home's Behaviour Support Lead.

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Date Remedy Implemented: March 15, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that when a resident's plan of care was ineffective at preventing falls, that it was reviewed and revised.

Rationale and Summary
On two consecutive dates, a resident fell while performing an activity of daily living.

A review of the plan of care for the resident, revealed that after the falls, no changes were made to the resident's care plan.

The resident fell a third time, while performing the same activity of daily living, which resulted in a significant change in the resident's condition.

A registered staff member acknowledged that they had not reviewed the resident's care plan after the second fall. Both the staff member and the Assistant Director of Care (ADOC) verified that the care plan for the resident should have been reviewed and revised, when the care set out in the plan of care, related to falls prevention, had not been effective.

There was moderate impact and risk for harm to the resident while performing a specific activity of daily living, when the plan of care was not reviewed and revised, when it had not been effective in reducing falls.

Sources: A resident's health record; the home's fall incident reports and policy titled, "Falls Prevention and Management", revised May 2022; and interviews with a registered staff member and the ADOC.

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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) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a

resident by anyone that resulted in harm or a risk of harm to the resident had occurred, immediately reported to the Director.

Rationale and Summary:
A staff member reported to a registered staff member, potential abuse of a resident by another resident. A Critical Incident was not submitted to the Director, by the home, until two days later.

The registered staff member verified that they did not report the allegations of abuse at the time of the incident and should have.

The failure of the registered staff member to immediately report the allegations of abuse, placed residents at potential risk for harm and led to a delay in the notification of the Director when an incident of potential abuse was witnessed.

Sources: Long-Term Care Homes portal; a resident's health record; the home's policy titled, "Prevention of Abuse and Neglect, Zero Tolerance", effective April 2022; the home's training records for a staff member; and interviews with two staff members.

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