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
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Original Public Report

Report Issue Date: September 21, 2023	
Inspection Number: 2023-1530-0004	
Inspection Type: Critical Incident	
Licensee: Board of Management for the District of Parry Sound West	
Long Term Care Home and City: Belvedere Heights, Parry Sound	
Lead Inspector Charlotte Scott (000695)	**Inspector Digital Signature** Charlotte A Scott Digitally signed by Charlotte A Scott Date: 2023.10.05 14:33:51 -04'00'
Additional Inspector(s) Samantha Fabiilli (000701) Michelle Berardi (679) and Keara Cronin (759) were also in attendance for this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5-7, 2023

The following intake(s) were inspected:

- One intake related to neglect of a resident by staff; and
- One intake related to improper/incompetent care of a resident that resulted in a fall with injury.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear direction to staff and others who provided direct care to the resident.

Rationale and Summary
A resident sustained an injury while being provided care by a staff member.

Prior to the incident, another staff member completed an assessment for the resident that identified a change in the resident's care requirements, however did not update the resident's care plan. The Director of Care (DOC) confirmed that following the assessment, the resident's care plan was not updated and should have been.

There was moderate impact and risk to the resident when the home failed to ensure that the plan of care provided clear direction to staff regarding the specific intervention.

Sources: LTCH investigation notes, the resident's plan of care, progress notes for the resident, the assessment for the resident, and interviews with the resident, the DOC, PSW staff and other registered staff.
[000695]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care, that resulted in harm or risk of harm to a resident, immediately reported the suspicion to the Director.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director on an identified date, for an allegation of improper resident care. However, the CI indicated that the incident had taken place 16 days earlier.

The staff who reported the incident was unable to recall when the alleged incident occurred, and confirmed that they did not report the allegation involving the resident immediately. The Administrator confirmed that the staff should have reported the allegation immediately.

Late reporting of this allegation of improper resident care resulted in low risk to the resident.

Sources: CI Report submitted for the incident; Interviews with staff and the Administrator.
[000701]