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: June 3, 2024	
Inspection Number: 2024-1530-0001	
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 Jennifer Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2024.06.06 11:38:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8-12, 2024.

The following intake(s) were inspected:

- Two Intakes were related to Improper/incompetent care of a resident.
- One Intake was related to disease outbreak.
- One Intake was related to allegation of neglect of a resident.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a resident's individualized care plan was implemented.

Rationale and Summary

It was noted in the resident's written plan of care that a resident required a specified intervention to be provided.

A review of the resident's progress notes indicated that during the identified shift, they did not receive this specified intervention by staff.

The Administrator verified that the PSW's did not follow the specified intervention to the resident as per the care plan.

The lack of personalized care placed the resident at moderate risk.

Sources: CIS report; review of the resident's electronic health; and interviews with PSW's, and the Administrator.

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WRITTEN NOTIFICATION: Twenty-Four Hour Admission Care Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 3.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living.

The licensee has failed to ensure that a twenty-four hour admission care plan, which included a resident's assessed activities of daily living/ADL was developed for a resident.

Rationale and Summary
A resident was not properly assisted with ADL by PSW's.

A review of the resident's progress notes indicated that the resident did not have an ADL assessment done by staff upon admission.

The Administrator indicated that the staff did not follow the homes policy by preforming a proper admission ADL assessment on the resident as required.

The failure to not complete an admission ADL assessment placed the resident at moderate risk due to potential for injury.

Sources: CIS report, a Resident's progress notes, and assessments; the home's investigation notes; home's policy titled, "Resident Care Plan Protocol-twenty-four hour Admission Care Plan"; interviews with an and the Administrator, and other staff.

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WRITTEN NOTIFICATION: Late Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
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.

The Licensee has failed to immediately report an allegation of neglect towards a resident to the Director.

Rationale and Summary
A Critical Incident (CI) Report was submitted to the Director via after hours report for an allegation of neglect towards a resident.

In an interview with the Administrator, they confirmed that the RPN did not immediately inform the home's management of the alleged neglect, which resulted in the incident being reported late.

The failure to immediately report the alleged neglect to the Director placed the resident at minimal risk.

Sources: CIS report, Review of the home's "Zero Tolerance of Prevention of Abuse and Neglect", last reviewed May 2023; review of a resident's electronic health records including progress notes and assessments; interviews with an RPN, and the Administrator.
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WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

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

Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to comply that interventions were implemented to mitigate and manage nutritional and fluid risks related to a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is an organized program of hydration for the home to meet the hydration needs of the resident.

Specifically, staff did not comply with the policy titled "Nutrition and Hydration, NR I 807.

Rationale and Summary

A critical incident (CI) was submitted to the Director regarding a resident's nutritional care needs.

A review of a resident's progress notes revealed documentation of altered nutritional care needs but failed to implement specific interventions.

The Administrator indicated the RN did not follow their current policy and procedure when nutritional and fluid risks were identified.

Failure to follow the home's policy to for a resident's nutritional care needs, caused the potential of moderate risk of harm to the resident.

Sources: CI report; a resident's progress notes, care plan, Point of Care (POC) charting, physician notes, and admission notes; licensee's policies titled "Nutrition and Hydration and NR I-807; the homes investigation notes; Interviews with an RN; and the Administrator.
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