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

Public Report

Report Issue Date: May 15, 2025
Inspection Number: 2025-1530-0002
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 12-15, 2025

The following intake(s) were inspected:

- One intake, related to improper care of a resident; and
- One intake, related to an allegation of Physical abuse

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

Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect two residents from physical abuse by a Personal Support Worker (PSW). The Administrator confirmed that the allegation of physical abuse was substantiated, and the residents were not protected from abuse.

Sources: The home's investigation notes, and staff files; interview with the Administrator.

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) 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 ensure that the Director was immediately notified of an allegation of physical abuse of residents. The PSW did not report the allegations to anyone until a number of days later.

Sources: A Critical Incident (CI) report; and an interview with the Administrator.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure staff used safe transfer techniques when transferring residents.

a) A resident who required the use of a device, to perform an activity of daily living (ADL), was assisted by staff to perform the ADL without the use of the device.

Sources: The home's investigation notes; a resident's care plan; and interview with the Administrator

b) A different resident who required a specified level of assistance from staff to perform an ADL, was provided with a different level of assistance to perform the ADL.

Sources: The home's investigation notes; a resident's care plan; and interview with the Administrator.

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