Ontario

# Inspection Report under the *Long-Term Care Homes Act, 2007*

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

| **Date(s) of inspection/Date de l'inspection** | **Inspection No/ d'inspection** | **Type of Inspection/Genre d'inspection** |
|---|---|---|
| December 7-10, 2010 | 2010_154_9503_08Dec094831 | Mandatory Report #M503-000020-10<br>Log # S00056 |

**Licensee/Titulaire**
Board of Management of the District of Parry Sound West, 21 Belvedere Avenue, Parry Sound, ON P2A 2A2
Fax: 705-774-7300

**Long-Term Care Home/Foyer de soins de longue durée**
Belvedere Heights
Fax: 705-774-7300

**Name of Inspector(s)/Nom de l'inspecteur(s)**
Gail Peplinskie #154

## Inspection Summary/Sommaire d'inspection

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

**Inspection Report under the *Long-Term Care Homes Act, 2007***

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The purpose of this inspection was to conduct a Mandatory Report Inspection.

During the course of the inspection, the inspector spoke with:
-Administrator
-Director of Care
-Assistant Director of Care
-Registered Nursing staff
-Personal Support Workers (PSW)
-Resident involved in Mandatory Report

During the course of the inspection, the inspector:
-Reviewed the health care record of the resident involved in the Mandatory Report
-Walked throughout one specific unit of the home
-Reviewed RAI MDS information for a specific resident
-Observed resident care specific to one resident, at various times during the inspection
-Observed dining service in one specific dining room at breakfast on one day of the inspection

The following Inspection Protocol was used during this inspection:
-Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection. The following actions were taken:

2 WN

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

| | |
|---|---|
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

**Findings:**
1. The plan of care for a resident does not provide clear directions to staff and others who provide direct care, related to bathing. The plan of care does not identify how 2 staff members are to bathe this resident.

2. The plan of care for a resident does not provide clear directions to staff and others who provide direct care, related to bladder incontinence.

3. The plan of care for a resident does not provide clear directions to staff and others who provide direct care, related to dressing.

4. The plan of care for a resident does not provide clear directions to staff and others who provide direct care, related to bed rails. The plan of care does not clearly identify how many bed rails are to be used and when.

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**WN #2:** The Licensee has failed to comply with O. Reg. 79/10, s. 21 Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

**Findings:**
**1**. On December 8, 2010 at 11:40 am the inspector noted while walking on a specific unit, that the hall was very cool. The temperature was checked and the thermometer registered 20.6 degrees Celsius. The air vent in the ceiling was expelling cool air. .

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| **Signature of Licensee or Representative of Licensee**<br>**Signature du Titulaire du représentant désigné** | **Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** |
|---|---|
| **Title:** **Date:** | **Date of Report:** Dec 21/10. |