

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

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 2, 2021	2021_668543_0016	005042-21	Critical Incident System

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**Licensee/Titulaire de permis**

The Board of Management for the District of Parry Sound East  
62 Big Bend Avenue Box 400 Powassan ON P0H 1Z0

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**Long-Term Care Home/Foyer de soins de longue durée**

Eastholme Home for the Aged  
62 Big Bend Avenue P.O. Box 400 Powassan ON P0H 1Z0

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

TIFFANY BOUCHER (543)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 10-11 and 14-15, 2021.**

**The following intake was inspected during this Critical Incident System inspection:**

**-one intake, related to alleged abuse.**

**A Complaint Incident inspection, was also conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Assistant Administrator/Environmental Service Manager, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW), family of residents and residents.**

**The Inspector also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:  
Infection Prevention and Control  
Prevention of Abuse, Neglect and Retaliation  
Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was complied with.

A critical incident report was submitted to the Director, which indicated that a resident had not been provided care on the previous shift.

The Inspector reviewed a resident's electronic progress notes, which indicated that a resident had not received care the day prior.

The Inspector reviewed the Zero Tolerance of Abuse, notification re Incident, Police Notification and evaluation policy. The policy defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In interviews with two PSWs, as well as the DOC and the ADOC verified that the resident had not been provided with care on a specific date in 2021.

Sources: Critical incident report, resident's electronic progress notes, internal investigation documents, Zero Tolerance of Abuse, notification re Incident, Police Notification and evaluation and interviews with PSWs and the DOC and ADOC. [s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that their policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.***

**Issued on this 28th day of July, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**