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

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Original Public Report

Report Issue Date: October 12, 2022	
Inspection Number: 2022-1542-0001	
Inspection Type: Critical Incident System	
Licensee: The Board of Management for the District of Parry Sound East	
Long Term Care Home and City: Eastholme Home for the Aged, Powassan	
Lead Inspector Shelley Murphy (684)	**Inspector Digital Signature** Shelley Murphy Digitally signed by Shelley Murphy Date: 2022.12.19 10:11:32 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): September 28-30, 2022.

The following intake(s) were inspected:

- Intake: #00006321-[CI: M517-000029-21] related to neglect of a resident.
- Intake: #00007092-[AH: IL-05059-AH/CI: M517-000018-22] related to physical abuse of resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: FLTCA Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided a resident as specified in the plan.

The Inspector observed a resident without an intervention that was in their care plan in place. A RPN (Registered Practical Nurse) and the DOC (Director of Care) confirmed that the resident should have had the intervention in place as specified in their plan of care.

The risk this resident as it relates to this non-compliance was moderate.

Sources: Home's policy titled "Plan of Care" effective date January 2018, resident observations, a resident's care plan, a RPN and DOC interviews.
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WRITTEN NOTIFICATION: LTCHA -Reporting

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure when 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: Abuse of a resident by a PSW that resulted in a risk of harm.

During review of the Critical Incident System (CIS) report, it was noted that an alleged abuse occurred, but was not reported immediately by a Personal Support Worker (PSW). The DOC stated the PSW should have immediately reported the alleged abuse.

Sources: CIS report M517-000029-21, Home's policy titled: "Zero Tolerance of Abuse, Notification re-incident, Police Notification and Evaluation", last reviewed June 2021, a PSW and DOC interviews.
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