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
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Original Public Report

Report Issue Date: April 22, 2024	
Inspection Number: 2024-1542-0001	
Inspection Type: Complaint Critical Incident	
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 Shannon Russell (692)	**Inspector Digital Signature**
Additional Inspector(s) Nicole Lemieux (721709) Arash Pouralborz #000837 was present during this inspection.	

INSPECTION SUMMARY

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

The following intake(s) were inspected:

- Intake: related to a disease Outbreak;
- Intake: related to a complaint submitted to the Director regarding concerns with resident care;
- Intake: related to an allegation of resident neglect by staff; and,
- Intake: regarding an allegation of Improper/incompetent care of resident by staff.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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

Rationale and Summary
A resident was provided assistance with a specific activity of daily living (ADL) by two Personal Support Workers (PSWs). A few moments after leaving the resident, the PSWs found the resident had sustained a fall, which resulted in them acquiring injuries.

The resident's plan of care identified that staff were to complete the ADL in a specified manner. The PSWs identified that they were not aware of the specifics

when completing the ADL for the resident; however, they indicated they did have access to the resident's plan of care prior to providing the resident with care.

The Director of Care (DOC) identified that staff were to provide residents with the care as specified in the residents' plan of care. They indicated that the PSWs had not provided the care to the resident as specified in their plan of care, which resulted in a moderate impact to the resident.

Sources: CIS report; complaint intake; a resident's health care records; the homes internal investigation notes; review of the home's policy titled, "Falls Prevention and Management Program", last reviewed June 28, 2018; and interviews with direct care staff, registered staff and the DOC. (692).