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: April 11, 2025
Inspection Number: 2025-1542-0002
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 7 - 11, 2025

The following intakes were inspected:

- One intake was related to the improper care of a resident by staff.
- One intake was related to the physical abuse of resident by resident.
- One intake was related to a missing controlled substance.

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

Resident Care and Support Services
Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect

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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that when the transfer care needs of a resident changed, their care plan was reviewed and revised as required.

Sources: A resident's electronic medical records; interviews with staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 that staff used safe transferring and positioning devices or techniques when assisting resident.

Sources: A resident's electronic medical records; the home's internal investigation notes; ARJO Slings Policy - Rev Dec 2024; interviews with staff.

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