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

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| **Report Issue Date:** July 14, 2025 |
| **Inspection Number:** 2025-1542-0003 |
| **Inspection Type:**<br>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 date(s): July 7-10, 2025

The following intake(s) were inspected:

- One intake, related to an allegation of staff to resident abuse;
- One intake, related to an allegation of resident to resident physical abuse; and
- One intake, related to a disease outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

## INSPECTION RESULTS

## WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 59 (b)**
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure interventions identified to minimize the risk of altercations and prevent potentially harmful interactions between co-residents were implemented.

A resident was required to have a specified intervention in place to mitigate the risk of altercations, due to responsive behaviours. On a specified date, the required intervention was not in place, which resulted in an incident between residents.

Sources: A resident's care plan and progress notes; the home's internal investigation notes; and interview with the Director of Care (DOC).

## WRITTEN NOTIFICATION: Infection prevention and control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce

transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms indicating the presence of an infection was monitored on every shift. During a resident's isolation period, symptom monitoring was not recorded on a number of shifts.

Sources: A resident's progress notes; the home's Outbreak Management Policy; and interview with the Infection Prevention and Control (IPAC) Lead.

## WRITTEN NOTIFICATION: Police notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 105**
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate Police service was notified when an allegation of sexual abuse towards a resident by a staff member was reported to the Director of Care.

Sources: The home’s internal investigation notes; interview with the DOC.

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to unsure that drugs were kept secure, in that a medication cart in the hallway, and medication room door on a resident unit was observed to be unlocked and unattended.

Sources: Observations during the inspection; interview with an RPN.

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