Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Public Report

Report Issue Date: November 20, 2025
Inspection Number: 2025-1542-0005
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 date(s): November 17-20, 2025.

The following intake(s) were inspected:

- One intake related to alleged physical abuse of a resident.

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.

A resident required an intervention for responsive behaviour management that was not in place when an altercation occurred.

Sources: Review of health records for the resident, the critical incident report and associated investigation notes; and, interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The proper use of personal protective equipment (PPE) was not followed when an identified staff member did not don the required PPE when interacting with a resident.

Sources: Inspector observation; outbreak line list; and, interviews with staff.