Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2019	2019_520622_0016	026041-18, 028829-18	Critical Incident System

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 TORONTO ON M5J 2S1

Long-Term Care Home/Foyer de soins de longue durée

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 27, 28, 2019, July 2, 3, 4, 5, 8, 9, 10, 11, 12, 2019

The following logs were completed during this inspection:

Log #028829-18/Critical Incident System report (CIS) #0962-000020-18 - related to alleged staff to resident physical abuse.

Log #026041-18/CIS # 0962-000017-18 - related to alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the acting DRC, the Resource Registered Nurse, the Admissions Coordinator, the Scheduling Clerk, Registered Nurses (RN), Personal Support Workers (PSW), and the residents.

During the course of the inspection, the inspector reviewed electronic and hard copy health records, the critical incident system reports, the licensee's investigation documentation, observed resident to resident interaction and resident care and services.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) 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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or unlawful conduct that resulted in a risk of harm to resident #002 occurred, reported the suspicion and the information upon which it is based to the Director immediately.

Critical Incident System report (CIS) #0962-000017-18 indicated that on a specified date, an incident of resident #003 to resident #002 unlawful conduct (sexual abuse) occurred which resulted in a risk of harm to the resident. The CIS report was submitted to the Ministry of Long-Term Care seven days after the incident occurred.

The Ministry of Long-Term Care after hours info-line, document # IL-60300-AH which was dated three days after the incident occurred, stated that a sexual altercation occurred between resident #003 and resident #002 on the specified date.

During an interview with inspector #622 on July 12, 2019, Resource Nurse /Registered Nurse (RN) #107 stated that they became aware of the incident of resident #003 to resident #002 sexual abuse which occurred on the specified date when they read about it on report the day following the incident. The Resource Nurse / (RN) #107 stated that they had observed the Acting Director of Resident Care #109 trying to complete the CIS report the day following the incident however was having difficulty. Resource Nurse / (RN) #107 stated that they had received a call from the Ministry of Long-Term Care three days after the specified date of incident and therefore believed the CIS report had been submitted the day after the incident occurred.

During an interview with inspector #622 on July 12, 2019, the Administrator stated that this incident of sexual abuse by resident #003 to resident #002 should have been reported immediately at the time of the incident on the specified date. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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 anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident., to be implemented voluntarily.

Issued on this 25th day of July, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.