Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 2, 2021	2021_505103_0014	009889-21, 009949-21, 012837-21, 015475-21, 016005-21, 016060-21, 016061-21, 016062-21, 017384-21, 017460-21, 018479-21	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

DARLENE MURPHY (103), MANON NIGHBOR (755)

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): November 15-19, 22-25, 2021.

Logs #009889-21 (CIS #0962-000020-21) and #017460-21 (CIS #0962-000040-21)-resident falls that resulted in injuries,
Logs #009949-21 (CIS #0962-000021-21), #013078-21 (CIS #0962-000031-21), #013663-21 (CIS #0962-000032-21), #015475-21 (CIS #0962-000035-21) and #016005-21 (CIS #0962-000038-21)-alleged incidents of staff to resident abuse,
Logs #012837-21 (CIS #0962-000027-21) and #017383-21 (CIS #0962-000039-21)-alleged incidents of resident to resident abuse and
Logs #016060-21, #016061-21 and #016062-21-follow ups to Compliance Orders issued during inspection #2021_621755_0021.

Note: A Written Notification and a Voluntary Plan of Correction related to O. Reg 79/10, s. 131 (2) was identified in a concurrent inspection #2021_505103_0015 dated December 2, 2021 and issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, screeners, housekeepers, Personal Support Workers (PSW), Behavioural Support PSW's (BSO PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Social Worker (SW), Activation Lead, RAI Coordinator, Medical Director, Director of Clinical Services, the Director of Care (DOC) and the Administrator.

During the inspection, the inspectors reviewed resident health care records including progress notes, plans of care and medication administration records (eMARs), required staff education, committee minutes and audits associated with the follow ups to the Compliance orders, and applicable policies related to abuse, medication management, skin and wound and falls, made staff and resident observations related to the provision of resident care, dining, and infection prevention and control (IPAC).

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2021_621755_0021	755
O.Reg 79/10 s. 8. (1)	CO #002	2021_621755_0021	755
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #003	2021_621755_0021	755

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure a resident's plan of care related to medication administration included clear directions to staff that provided their care.

A resident became agitated when the RPN failed to provide their scheduled medication/treatment. An RN and PSW both indicated the resident liked to receive their medications at specific times and this was a known trigger for their behaviours.

The resident's plan of care related to medication administration was reviewed and failed to identify this as a potential trigger for behaviours. [s. 6. (1) (c)]

2. The licensee failed to ensure a resident’s plan of care related to responsive behaviours was provided as outlined in the plan of care.

A resident became agitated when the RPN failed to provide their scheduled medication/treatment. Interventions outlined in the resident’s plan of care related to responsive behaviours were not provided.

Sources: review of the resident eMAR, and interviews with the resident and staff members. [s. 6. (7)]

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 to ensure the resident's plan of care includes clear directions related to medication administration and to ensure the resident's plan of care related to responsive behaviours is provided as outlined in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

O. Reg 79/10, s. 114 (2) requires the licensee to have written policies and procedures to ensure the accurate dispensing and administration of all drugs used in the home.

Specifically, staff did not comply with the pharmacy policies related to the reordering of medications and the emergency starter box.

A resident did not receive their prescribed pain medications for a period of twelve hours due to the unavailability of the medication in the home. The resident required additional interventions to address their management of pain.

An RN stated staff believed the medication had been reordered the previous week, but failed to contact the pharmacy for confirmation. The reorder policy indicates to check with pharmacy if a new supply of medication is not received when a 2-day supply remains.

An RN stated the home keeps a supply of the prescribed pain medications in the home's emergency box. Upon review of the emergency supply, it was noted the supply had been depleted for more than a week. The RN confirmed the policy states to notify pharmacy with each use from the emergency starter box such that each emergency medication used can be replaced with the next delivery.

Sources: interviews with staff, review of pharmacy policies related to the reordering of medications and the emergency starter box. [s. 8. (1) (b)]

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 to ensure staff comply with the pharmacy policies for reordering medications and utilizing medications from the emergency starter box, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure procedures were implemented to assist residents and staff at risk of harm or harmed as a result of a resident's responsive behaviours.

A resident and a staff member were involved in a verbal altercation that escalated and resulted in injuries to the resident. During the incident, staff who witnessed and were in the vicinity of the incident failed to intervene and provide measures to de-escalate the situation. The DOC indicated staff should have utilized gentle persuasive approaches (GPA), separated the involved staff member and the resident and provided distraction and support to the resident in an attempt to resolve the issue.

Sources: review of the critical incident submitted to report this incident, and interview with DOC. [s. 55. (a)]

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 to ensure de-escalation procedures for responsive behaviours are implemented to mitigate risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On three separate occasions, a total of five residents reviewed did not receive their prescribed medications.

Sources: Resident eMAR's and interview with DOC. [s. 131. (2)]

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 to ensure medications are administered as prescribed, to be implemented voluntarily.

WN #5: 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. A person who had reasonable grounds to suspect the abuse of a resident failed to immediately report the suspicion and information upon which it was based to the Director.

A resident reported they had been physically struck by a PSW. The RPN spoke with the resident regarding the alleged incident and stated the resident was unclear on when the incident occurred. The RPN stated they examined the resident for injuries, found none and did not report the incident to anyone. The RPN acknowledged the alleged incident of resident abuse should have been immediately reported to facilitate an investigation into the allegations.

Sources: review of the critical incident submitted to report this incident and interview with the RPN. [s. 24. (1)]

Issued on this 3rd day of December, 2021

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

Original report signed by the inspector.