

# 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

#### **Ottawa District**

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

## **Public Report**

Report Issue Date: February 20, 2025 Inspection Number: 2025-1014-0002

**Inspection Type:**Critical Incident

**Licensee**: 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

Long Term Care Home and City: Perth Community Care Centre, Perth

## **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): February 18-20, 2025.

The following Critical Incident (CI) intake(s) were inspected:

• Intake: #00137551 related to alleged resident to resident abuse.

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

Infection Prevention and Control Prevention of Abuse and Neglect Responsive Behaviours

### **INSPECTION RESULTS**

WRITTEN NOTIFICATION: Infection prevention and control program



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NC #001 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 licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard 9.1 (b) issued by the Director, defined as: 9.1 the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact; was followed by a staff member.

In February 2025, a staff member was observed failing to perform hand hygiene according to the four moments of hand hygiene, following resident contact and before and after entering multiple residents' spaces and making contact with the environments.

Sources: Observations