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

Ottawa District
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Public Report

Report Issue Date: April 28, 2025
Inspection Number: 2025-1014-0004
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): April 22-25, 2025

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

- Intake #00142583 (CI #0962-000016-25) - Improper/Incompetent care of resident by staff;
- Intake #00142804 (CI #0962-000017-25) - Alleged verbal/emotional resident to resident abuse; and
- Intake #00142911 (CI #0962-000018-25) - Alleged physical resident to resident abuse.

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

Resident Care and Support Services
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that safe transferring and positioning techniques were used when a Personal Support Worker (PSW) attached a resident to the mechanical lift without following safe transferring techniques; and left the resident unattended on the lift.

Sources: Resident #001's health care record; investigation documents; Safe Operating Procedure (SOP) Resident Transfers - Using Lifts Safely, Index I.D.: Q-05-40, reviewed March 9, 2025; and interview with PSW #102, ADOC/IPAC Lead #103 and Administrator #101.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment,

reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches to care were developed for a resident's needs related to physically responsive behaviours.

A resident was physically responsive with other residents on several occasions. Written approaches to care for the resident's physically responsive behaviours were not documented until after the most recent incident.

Sources: Resident #002's health care record; CI #0962-000009-25; CI #0962-000034-24; and interview with PSW #106, ADOC/IPAC Lead #103 and staff.