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

Public Report

Report Issue Date: September 12, 2025
Inspection Number: 2025-1014-0006
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): September 9, 10, and 11, 2025.

The following Critical Incident (CI) intake(s) were inspected:
-Intake 00152146 (CI 0962-000029-25) and Intake 00155768 (CI 0962-000032-25) - related to fall of a resident resulting in transfer to hospital and injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan. Specifically, a resident was to have a bed alarm in place as a falls prevention measure. On a date in September, 2025, the resident did not have a bed alarm in place, and a Personal Support Worker (PSW) stated that there had not been one in place for at least a week.

Sources: resident's care plan; progress notes by a Registered Practical Nurse (RPN) on two dates in September, 2025; Documentation Survey Report, September 2025; q15 minute checks; and interview with Behavioural Supports Outreach (BSO) PSW, a PSW, and RAI/MDS Coordinator.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for a resident. The resident's plan of care indicated that a bed alarm was used as a preventative measure for falls; and use of the bed alarm should be documented on Point of Care (POC) by the Personal Support Workers (PSW). Review of POC revealed no documentation by PSW's on the use of a bed alarm for the resident.

Sources: resident's care plan; Documentation Survey Report, August 2025; Kardex; CI 0962-000032-25; and interviews with RAI/MDS Coordinator, two PSW's, an RPN and the Director of Care (DOC).

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