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

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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
Jul 25, 2019	2019_520622_0014	010916-19	Complaint

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 Complaint 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 log was completed during this inspection:

Log #010916-19 for a complaint related to resident care and services, sufficient staffing and personal support worker qualifications.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Manager of CQI and Risk, the Office Manager, the Scheduling Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the residents.

During the course of the inspection, the inspector reviewed electronic and hard copy health records, bathing schedules, staffing schedules, the licensee's staffing plan, documentation and service agreements specific to agency staff, the licensee's documentation related to power outages, union heavy workload reports and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Safe and Secure Home
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that the care set out in the plan of care for residents #008 and #009 was provided to the residents as specified in the plan for toileting/continence care on a specified date.

Resident #008's most recent care plan stated that the resident was to be toileted before and after meals, at bedtime and when needed.

Resident #009's most recent care plan stated that the resident was to be toileted every two hours.

During an interview with inspector #622 on a specified date, Personal Support Worker (PSW) #109 and PSW #114 stated that they were working short staffed on the floor on that date. PSW #109 and PSW #114 stated that when working short staffed they try to toilet all residents however this does not always occur. Both PSW #109 and PSW #114 stated that due to working short staffed they had not been able to perform resident #008's and #009's toileting/continence care after breakfast or lunch until a specified time on that date.

During an interview on July 10, 2019, inspector #622 and the Administrator reviewed the Personal Support Worker schedules dated for the specified date and the care plans for residents #008 and #009. The Administrator stated that PSW staff #109 and #114 had not followed the toileting plan of care for residents #008 and #009 on the specified date when they did not provide continence care to the two residents on the specified date. [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 the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #005 and #006 have been bathed, at a minimum, twice a week by the method of their choice.

A review of the most recent care plan for resident #005 stated that the resident prefers a tub bath for all bathing twice weekly.

A review of the most recent care plan for resident #006 stated that the resident prefers a tub bath for all bathing twice weekly.

A review of the Assignment Sheet dated a specified date indicated that resident #005 was given a bed bath.

A review of the Assignment Sheet dated a specified date indicated that resident #006 was given a bed bath.

During separate interviews with Inspector #622 on July 9, 2019, RN #104 and PSW #105 stated when working short PSW staff, sometimes residents are given bed baths in place of their routine baths. On two separate specified dates, resident #005 and resident #006 each received bed baths instead of their scheduled tub baths of choice. Residents #005 and #006 were not able to offer consent for the change in care and their substitute decision makers were not notified. RN #104 further stated that the baths given as bed baths due to PSW staff shortages would not be rescheduled for another time as a bed bath was considered a bath.

During an interview on July 10, 2019, the Administrator stated that the staff had not provided residents #005 and #006 their preferred choice of tub bath on specified dates when the residents were provided a bed bath rather than a tub bath. [s. 33. (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 every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an environmental hazard such as a loss of essential services on October 28, 2018 that affected the safety, security or well-being of one or more residents for a period greater than six hours.

On July 5, 2019, inspector #622 reviewed the licensee's document titled; "risk form" which was dated for a review period of January 2018 to November 2018. The risk form indicated that there was a power outage for 7 hours on Sunday October 28, 2018. This was a planned power outage by Hydro One, however Perth Community Care Centre had not been notified.

During an interview with inspector #622 on July 10, 2019, the Administrator stated that during the power outage on October 28, 2018, the magnetic door locks did not function. The Administrator further stated with the loss of essential services this incident should have been reported to the Ministry of Long-Term Care.

A critical incident was not submitted to the Ministry of Long-Term Care related to this seven hour power outage on October 28, 2018. [s. 107. (3) 2.]

Issued on this 25th day of July, 2019

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

Original report signed by the inspector.