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
Sep 16, 2019	2019_627138_0017	001373-19, 005442-19, 009496-19, 012674-19, 013398-19, 014530-19	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

PAULA MACDONALD (138)

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): September 4, 5, 6, 8, 9, and 10, 2019.

The following intakes were inspected during this CIS inspection:

log #001373-19, log #005442-19, log #009496-19, and log #012674-19 relating to alleged abuse of a resident,

and,

log #013398-19 and log #014530-19 relating to injuries to a resident for which the resident is taken to hospital that results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Behavioural Support Ontario (BSO) workers, the Continuous Quality Improvement (CQI) and Risk Manager, the Director of Resident Care, the Environmental Coordinator, the Resource Nurse, registered nurses (RNs), registered practical nurses, residents, the Scheduling Clerk, and personal support workers.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse of residents was complied with, with respect to the reporting of abuse.

A critical incident report was reviewed in which PSW #118 was alleged to abuse resident #002. Discussion was held with CQI and Risk Manager #101 who stated that PSW #119 had observed the incident involving PSW #118 and resident #002 but did not report the incident until 9 days later, when it was reported to the CQI and Risk Manager and the Director of Resident Care. The CQI and Risk Manager confirmed that PSW #118 continued to work with residents in the nine days after the incident. CQI and Risk Manager stated that PSW #119 provided no explanation for the delay in reporting. PSW #119 is no longer employed at the home.

Discussion was held with Director of Resident Care #106 who stated that they were present with the CQI and Risk Manager when PSW #119 had reported the incident between PSW #118 and resident #002 that occurred nine days prior. The Director of Resident Care confirmed that PSW #119 did not report the incident immediately.

The CQI and Risk Manager provided the policy on zero tolerance of resident abuse that was in effect at the time of the incident. The policy was reviewed and it was noted that the policy directs all staff to immediately report resident abuse to their supervisor.

In this incident, PSW #119 failed to follow the zero tolerance of resident abuse policy by failing to immediately report the incident between PSW #118 and resident #002, instead reporting the incident nine days later.

Log #05442-19 [s. 20. (1)]

2. In a second incident, a critical incident report was reviewed in which RN #117 was alleged to abuse resident #001. The CQI and Risk Manager stated that, during the course of the internal investigation into this alleged abuse incident, reports were received from other staff members alleging further potential abuse of other residents by RN #117. The inspector spoke with three of the staff members identified in the internal investigation. All were able to recount incidents of alleged abuse by RN #117 to residents and all stated that the incidents were not reported immediately citing specific reasons for not reporting immediately.

In this incident, the three staff members interviewed and other staff determined by the CQI and Risk Manager, failed to follow the zero tolerance of resident abuse policy by

failing to immediately report incidents of alleged resident abuse by RN #117.

Log #001373-19 [s. 20. (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 to ensure the licensee that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #2: 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. The licensee failed to ensure that management of the home who had reasonable grounds to suspect abuse of residents by a staff member that resulted in a risk of harm to the residents failed to report the suspicion and the information upon which it is based to the Director.

A critical incident report was reviewed in which RN #117 was alleged to abuse resident #001. During the course of the internal investigation into this alleged abuse incident, the management team received reports from staff members alleging further abuse of other residents by RN #117. The internal investigation lead to disciplinary actions of RN #117. The letter of discipline for RN #117 outlined that the cause for discipline was due to the abuse in the critical incident report as well as the reported abuse by staff members during the investigation.

Discussion was held with Administrator #100, CQI and Risk Manager #101, and Director of Resident Care #106 regarding the reports of further abuse of residents by RN #117 not included in the critical incident report. It was determined that the further reports of abuse were not reported to the Director.

Log #01373-19 [s. 24. (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 to ensure that any person who has reasonable grounds to suspect abuse of a resident by anyone that resulted on harm or risk of harm to the resident shall report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 23rd day of September, 2019

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

Original report signed by the inspector.