Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2020	2020_770178_0002	021856-19	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

SUSAN LUI (178)

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): January 27, 28, 29, 2020 onsite; January 30, 2020 offsite.

Log #021856-19/CIR #0962-000023-19, regarding a resident to resident altercation was inspected.

During the course of the inspection, the inspector(s) spoke with residents, a resident's family member, Personal Support Workers (PSWs), a Behavioural Support Worker, Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Director of Resident Care, and the Manager of Continuous Quality Control and Risk.

During the course of this inspection, the inspector also observed the provision of care and services to residents, observed residents' environment, reviewed residents' health records, reviewed licensee policies and training records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act (LTCHA).

Progress notes for resident #001 and resident #002 indicated that on an identified date, the residents were involved in an altercation with each other, resulting in minor injuries to each resident.

RPN #104 indicated that on the evening of an identified date, staff was made aware that resident #001 and resident #002 were involved in an altercation. RPN #104 indicated that both residents sustained minor injuries. RPN #104 indicated that they reported the incident to the RN on duty, who would normally report an incident of one resident causing injury to another resident to the Ministry of Long-Term Care.

Inspector #178 reviewed the Critical Incident System, in which the licensee should report any suspected incidents of resident abuse, and there was no report of the incident.

The Director of Resident Care (DRC) indicated that the RN on duty should have reported the incident of resident to resident abuse to the Ministry of Long-Term Care using the after hours phone number, and a Critical Incident Report would be submitted by the DRC on the next business day. The DRC indicated that they had not been made aware of the altercation between resident #001 and resident #002, and no Critical incident Report was submitted to the Ministry of Long-Term Care to report the incident.

RN #109 indicated that RPN #104 informed them of the resident to resident altercation on the identified date, but RN #109 did not call to report it to the Ministry of Long-Term Care, as they were uncertain of whether or not the incident needed to be reported. [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 that abuse of a resident by anyone has occurred, does immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act, to be implemented voluntarily.

Issued on this 3rd day of February, 2020

[redacted]

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

Original report signed by the inspector.