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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 2, 2022	2022_873602_0006	003285-22, 003289-22, 003292-22	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

WENDY BROWN (602), DARLENE MURPHY (103)

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): February 22 - 25 & 28, 2022

The following inspections were completed:
Log #003285-22/CIS #0962-000006-21 - regarding registered nurse certification
Log #003289-22/CIS #0962-000002-21 - regarding alleged resident to resident physical abuse
Log #003292-22/CIS #0962-000007-21 - regarding alleged resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC), Recreation/Activities staff, the Infection Prevention and Control (IPAC) lead, the Physiotherapist, the Social Worker, Screening and Housekeeping staff, residents, family members and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care, progress notes, relevant policies and procedures, and made resident care/service and IPAC practice observations.

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

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	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 O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee has failed to ensure a Registered Nurse (RN) had the appropriate current certificate of registration with the College of Nurses of Ontario.

An agency RN completed several orientation shifts and subsequently worked as the charge nurse in the home for two shifts. It was then discovered that the RN was not registered with the College of Nurses of Ontario and this was reported to the Director of Care (DOC). An investigation was immediately initiated and the RN was terminated. The home also cancelled the contract with the Agency.

Sources: interview with DOC, home's investigation into the incident and the critical incident report [s. 46.]

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 staff performing registered nursing duties in the home hold an appropriate and current certificate of registration with the College of Nurses of Ontario, to be implemented voluntarily.

Issued on this 3rd day of March, 2022

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

Original report signed by the inspector.