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
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Original Public Report

Report Issue Date: July 8, 2024	
Inspection Number: 2024-1014-0005	
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	
Lead Inspector Saba Wardak (000732)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3-5, 8, 2024

The following intake(s) were inspected:

- Intake #00116302/ CI #0962-000015-24, Intake #00116613/ CI# 0962-000016-24 and Intake #00117513/ CI# 0962-000019-24-related to alleged resident to resident physical abuse
- Intake #00116829/ CI #0962-000017-24 - related to safe and secure home

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect

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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there is a written plan of care for a resident that sets out the planned care for the resident. Specifically, resident's written plan of care did not include written interventions and strategies to manage resident's wandering and exit seeking behaviours.

Sources: Resident's written plan of care, interviews with DOC and other staff.

[000732]