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
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Public Report

Report Issue Date: March 19, 2025
Inspection Number: 2025-1014-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17, 18, and 19, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake 00136853 (CI 0962-000003-25)- Improper/Incompetent care of a resident by staff.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that safe transferring techniques were used when a Personal Support Worker transferred two residents.

Sources: resident #001 health care record; investigation documents; Safe Operating Procedure (SOP) Resident Transfers - Using Lifts Safely, Index I.D.: Q-05-40, reviewed March 9, 2025; and interview with resident #001, resident #002, PSW #101, and other staff.