



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 le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Sep 26, 2011, 2011_092121_0019, Critical Incident

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
671 Frank Street, WIARTON, ON, N0H-2T0

Long-Term Care Home/Foyer de soins de longue durée

GATEWAY HAVEN LONG TERM CARE HOME
671 FRANK STREET, P.O. BOX 10, WIARTON, ON, N0H-2T0

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

ELIZABETH ELVIDGE (121)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator and the Director of Care.

During the course of the inspection, the inspector(s) Reviewed the contents of the Critical Incident, the policies and procedures on Abuse and Neglect and the handbook provided to staff, contract persons and volunteers.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend, Legendé. Lists abbreviations for Written Notification, Voluntary Plan of Correction, Director Referral, Compliance Order, Work and Activity Order.

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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.**
- 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.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits saillants :

1. Sept 26, 2011 - 14:03 - Date of the Incident was July 13, 2011 and it was reported through a Critical Incident on July 19, 2011.

Issued on this 26th day of September, 2011

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

Elizabeth Clendinning