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
Jun 25, 2020	2020_796754_0015	001539-20, 005720-20, 011078-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

TAWNIE URBANSKI (754)

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): June 18, 19, 22, 23, 2020.

The following intakes were completed during this Critical Incident Inspection:
Log #0057020-20, related to falls prevention management,
Log #001539-20, related to a medication incident,
Log #11078-20, related to a complaint of an allegation of abuse/neglect towards a resident at the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse's (RN's), Registered Practical Nurse's (RPN's), Personal Support Workers (PSW's), and residents.

The inspector made observations of resident care and resident/staff interactions. A record review of the plan of care of the identified residents was completed. The home's relevant policies and procedures and related documentation were also reviewed.

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

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 26 (1), and in reference to O. Reg. 79/10, s. 26 (3) 18, the licensee was required to ensure the plan of care included an interdisciplinary assessment of the resident's safety risk. Specifically, staff did not comply with the licensees policy related to treatment of a specific medical condition, which directed staff to provide a prescribed treatment, monitor the resident's response to treatment and provide treatment until the resident was no longer experiencing the medical condition.

A critical incident (CI) was submitted to the Ministry of Long-term Care (MLTC) in relation to an incident where resident #003 experienced a medical condition requiring a prescribed treatment and transfer to hospital.

The home’s policy, directed staff to provide residents with a prescribed treatment when they were experiencing this medical condition. Registered staff were then to recheck the resident's response to treatment 15 minutes after. If the resident were still experiencing the specific medical condition, registered staff were to repeat the treatment and recheck the resident's response to treatment 15 minutes after. The policy instructed staff to document findings in the progress notes.

Documentation in resident #003's plan of care completed on a specific date in January 2020, stated the resident was experiencing a specific medical condition that required a prescribed treatment. A progress note indicated an initial prescribed treatment was provided to the resident. On two different occasions, between one and four hours later,

documentation stated that the resident was still experiencing the specific medical condition and would be monitored, but did not indicate that any form of treatment was administered.

A progress note stated that resident #003 required immediate medical attention and the physician directed staff to ensure the resident received emergency medical attention.

RPN #104 said it was the home's expectation when any resident experienced this specific medical condition they were to receive treatment and ongoing monitoring until they were no longer experiencing symptoms. If any resident needed immediate medical attention for this condition they would call the physician immediately while at the same time administering treatment.

DOC #101 said resident #003's response to treatment should have been checked more frequently and they should have been treated according to the home’s policy when the resident was experiencing the specific medical condition. They would have expected the physician and emergency medical services to have been contacted sooner.

The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with. [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system in relation to Diabetes management was complied with, to be implemented voluntarily.

Issued on this 3rd day of July, 2020

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

Original report signed by the inspector.