

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 18, 2024
Inspection Number: 2024-1548-0004
Inspection Type: Critical Incident Follow up
Licensee: Corporation of the County of Bruce
Long Term Care Home and City: Gateway Haven Long Term Care Home, Wiarton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-7, 12-13, 2024

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

- Intake #00123700 was related to infection prevention and control.

The following intake(s) were inspected in this Follow-up inspection:

- Intake #00124469 - Follow-up #:1 - CO #001 from 2024_1548_0003 - FLTCA, 2021 - s. 24 (1) related to reporting certain matters to the Director, and
- Intake #00124470 - Follow-up #: 1 - CO #002 from 2024_1548_0003 - FLTCA, 2021 - s. 28 (1) 2 was related to abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1548-0003 related to FLTCA, 2021, s. 24 (1) inspected by Tanya Murray (000735)

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Order #002 from Inspection #2024-1548-0003 related to FLTCA, 2021, s. 28 (1) 2.
inspected by Tanya Murray (000735)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that any directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health with respect to infection prevention and control is followed.

Specifically, the Recommendations for Outbreak Prevention in Institutions and Congregate Living Setting - April 19, 2024, indicates that during a COVID-19 outbreak the infection prevention and control (IPAC) Lead/designate should conduct weekly IPAC audits for the duration of the outbreak.

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Rationale and Summary

The IPAC lead confirmed that one IPAC self-assessment audit was completed during an outbreak in the home.

The audit tool had not been completed during the first weeks of the outbreak.

Failure to complete the recommended IPAC audits could result in the spread of infection.

Sources: Record review, Recommendations for Outbreak Prevention in Institutions and Congregate Living Setting - April 19, 2024, and interview with staff.