**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**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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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 13, 2015 | 2015_182128_0008 | 002794-15 | Complaint |

**Licensee/Titulaire de permis**

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street P.O. Box 1600 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**

RUTH HILDEBRAND (128)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): April 8, 2015**

**This Complaint Inspection was related to IL-37396-LO.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Care Coordinator, 1 Registered Nurse, 5 Personal Support Workers, 1 Dietary Aide and 1 Student.**

**The Inspector observed care provided to residents, observed staff-resident interactions, reviewed pertinent clinical records, and reviewed posted information, policies and procedures, and training records.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Personal Support Services**
**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care for each resident provided clear directions to staff and others who provided direct care to the resident.

A clinical record review for Resident #003 revealed inconsistencies between the nursing and physiotherapy plans of care. The physiotherapy care plan indicated that the resident was able to transfer with the assistance of one person but the nursing care plan indicated that extensive assistance was required and for safety reasons the resident was a two person transfer.
The Resident Care Guide in the resident's room indicated that two people were required to transfer and toilet the resident.

A Personal Support Worker and a Student acknowledged that the resident was transferred to use the washroom with a one person transfer.

A Registered Nursing staff member indicated that the staff did not have clear direction in regard to transferring the resident due to the inconsistencies in the nursing and physiotherapy plans of care.

The Director of Care acknowledged the expectation was that plan of care for each resident set out the intended care for the resident with clear direction provided for all staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A clinical record review revealed that Resident #004 sustained a significant change in condition after being transferred by a Personal Support Worker with a one person transfer.

The plan of care indicated that extensive physical assistance of two staff was required for the resident to transfer/ambulate for safety reasons.

The Director of Care acknowledged that the care set out in  plan of care was not followed for this resident. [s. 6. (7)]

***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 plans of care provide clear directions to staff and that the care set out in each resident's plan of care is provided to the resident, to be implemented voluntarily.***

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**Issued on this 20th day of April, 2015**

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

**Original report signed by the inspector.**