Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2019	2019_755728_0012 (A1)	013175-18, 020997-18, 021730-18, 024066-18, 025040-18, 027474-18, 027619-18, 027791-18, 028601-18, 028993-18, 029107-18, 029406-18, 029952-18, 030924-18, 030925-18, 030926-18, 030927-18, 001366-19, 004585-19, 005186-19, 007401-19, 008057-19, 010637-19	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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Incorrect dates identified in the report

Issued on this 29th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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Amended by MARIA MCGILL (728) - (A1)

Amended 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 10-14, 17-21, 24-28, 2019

Inspector, Katherine Adamski #753 attended this inspection during orientation.

The following intake(s) were completed as part of this inspection:

Log #030924-18, related to follow-up to CO #001 from inspection 2018_750539_0006, s.19 (1), duty to protect;

Log #030925-18, related to follow-up to CO #002 from inspection 2018_750539_0006, s. 20 (1), complying with home's policy to promote zero tolerance of abuse and neglect;

Log #030926-18, related to follow-up to CO #003 from inspection 2018_750539_0006, s. 24 (1), reporting certain matters to the Director;

Log #030927-18, related to follow-up to CO #004 from inspection 2018_750539_0006, s. 50 (2), completing weekly skin and wound assessments;

Log #001366-19, related to follow up to CO #001 from inspection 2018_723606_0024, s. 8 (3), 24/7 RN.

Log #027474-18, Log #029406-18, related to alleged verbal abuse;

Log #008057-19, Log #025040-18, Log #004585-19, Log #024066-18, Log# 007401-19, related to alleged resident to resident sexual abuse;

Log #029952-18, Log #013175-18, Log #021730-18, Log #028993-18 related to falls;

Log #029107-18, related to a missing resident;

Log #005186-19, Log #020997-18, Log #027791-18, Log #027619-18, Log #028601-18, related to alleged staff to resident abuse;

Log #010637-19, related to alleged visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (Acting DOC), the Former Director of Care (FDOC), the Nutrition Manager (NM), the Dietitian (RD), the Physiotherapist (PT), the Recreation and Leisure Manager (RLM), the Physiotherapist Assistant (PTA), Guest Services Receptionist (GSR), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), visitors, and volunteers.

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations, and education and training documentation.

Observations were made of residents, staff to resident interactions, and resident care provision.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.

9 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_750539_0006	728
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2018_750539_0006	728
O.Reg 79/10 s. 50. (2)	CO #004	2018_750539_0006	633

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

This inspection was completed as a follow-up to compliance order #001 from inspection 2018_723606_0024 issued on January 16, 2019, with a compliance date of May 16, 2019.

A review of the home's staffing schedules from May 16 to June 10, 2019, identified that nine percent of RN shifts did not have an RN on duty and present in the home.

RPN #104 said that there were occasions after May 16, 2019, where they were the only registered staff in the building.

RN #105 said that there was no RN in the home for night shift on June 6, 2019, and a registered staff shortage occurred on June 1 and 2, 2019.

Administrator #100 said that the home has not been able to fill the RN staffing complement and an RN was not on duty and present in the home for seven shifts between May 16 to June 10, 2019.

The home failed to ensure that they had an RN on duty and present in the home nine percent of the time from May 16 to June 10, 2019. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

This inspection was completed as follow-up to compliance order #002 from inspection 2018_750539_0006 issued on October 10, 2018, with a compliance date of February 8, 2019.

A) The home's policy titled "Prevention of Abuse & Neglect of a Resident", dated July 2018, and in effect at the time of the incidents, directed staff that all cases of suspected or actual abuse must be reported immediately to the Administrator or DOC. It also directed the Administrator or DOC to request written statements describing the event from anyone aware of or involved in the situation.

i) A Critical Incident report (CI) was submitted to the Ministry of Long-Term Care (MLTC), that reported an incident of alleged staff to resident abuse. The CI documented PSW #111 was unsure of the exact date the incident occurred. Staff member #111 said that a registered staff assisted resident #032 with a an activity of daily living and did not complete their care before leaving the resident.

Staff member #111 reported the incident in an email, sent to Administrator #100 and former DOC #107.

Administrator #100 stated that at the time of this incident, staff were directed to report all instances by e-mail or phone. Administrator #100 said PSW #111 did not report this incident to management until two days after the incident occurred and that they should have reported it immediately.

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of resident #032.

ii) A CI was received by the MLTC related to an incident of alleged resident to resident physical abuse.

The CI documented that PSW #109 and PSW #114 found resident #020 in resident #015's room and witnessed an altercation.

Risk management was completed for resident #015 and resident #020 related to the incident. There was no documented witness statements in risk management. The home was unable to provide any other investigative notes related to the incident.

Administrator #100 said that witness statements were not completed for this incident of alleged abuse.

The licensee failed to ensure that witness statements were completed by the staff that witnessed the incident of alleged abuse between resident #020 and #015, as required by the home's policy to promote zero tolerance of abuse and neglect.

B) The home's zero tolerance of abuse and neglect policy, titled Prevention of Abuse & Neglect of a Resident, last revised January 2019, directed registered staff to immediately report any incidents to the Director of the Ministry of Long-term Care through the Administrator or DOC by phone call.

i) A CI was submitted to the MLTC two days following an incident of alleged visitor to resident abuse.

PSW #125 said that they reported the incident to RPN #129. RPN #129 did not report the incident to management. No relevant progress notes were noted in the resident's chart on this date.

RN #123 said that two days following the incident, they overheard staff discussing the incident and reported it to management.

Administrator #100 said that staff were to report incidents of alleged abuse immediately to the Administrator or DOC by phone call. They said that they were in the building at the time of the incident and and it was not reported to them or

the DOC as required by the home's policy. They said they became aware of the incident, two days later, after receiving a phone call from RN #123.

The licensee failed to ensure that staff reported the incident of alleged abuse of resident #005 immediately, as required by the home's policy to promote zero tolerance of abuse and neglect. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A) A critical incident (CI) was submitted to the Ministry of Long-term Care (MLTC) in relation to an incident where resident #001 reported that they were not provided care in a manner they felt was appropriate.

The home's documentation included a statement from PSW #111, who said they were unaware of any concerns regarding their care during that shift. They said resident #001 did refuse care from another staff member and they had more trouble than usual assisting the resident with their care.

RN #123's statement documented that resident #001 did not report increased pain and denied interventions for pain following the incident.

Resident #001 said that PSW #111 did not intentionally hurt them but that due to their medical diagnoses they required care to be provided in a certain way.

Resident #001 said that they felt horrible and perplexed following the incident. They said that they did not sustain in injury following the incident.

Resident #001 was not treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity by PSW #111.

B) A CI was submitted to the MLTC that reported alleged staff to resident verbal abuse that occurred five days prior to the CI being reported. The CI documented that staff reported a fellow staff member swore at resident #029 when they were providing care.

Resident #031, who witnessed the alleged incident, said that staff should not talk like that and they were surprised and stunned that staff acted that way.

PSW #122 said they witnessed the incident and considered this behaviour to be verbal abuse. They said that resident #029 was agitated but was not able to verbalize they were upset at the time of the incident. RN #143 stated that profanity in the presence of a resident was not consistent with the residents bill of rights.

The licensee has failed to ensure that resident #029 was treated with courtesy and respect and in a way that fully respects the resident's dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has the right to be cared for in a manner consistent with their needs.

A CI was submitted to the MLTC reported alleged staff to resident abuse. PSW #111 said that a registered staff provided a resident assistance with an activity of daily living and left them alone before finishing the care.

The home's investigation notes included an interview with the registered staff where they acknowledged that they did not complete the care for the identified resident.

PSW #110, RN #143, and Administrator #100 stated that not finishing the resident's care and leaving them in this state was not consistent with the residents' bill of rights.

The licensee has failed to ensure that resident #032 was cared for in a manner consistent with their needs. [s. 3. (1) 4.]

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 the rights of residents are fully respected and promoted, to be implemented voluntarily.

WN #4: 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. (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 :

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 CI was submitted to the MLTC related to an incident of alleged staff to resident neglect. The CI documented that PSW #125 did not provide resident #018 with an intervention twice during a shift on an identified date.

Resident #018's plan of care, at the time of the incident, documented that this identified intervention was to be provided to the resident when they were unattended.

RPN #127 said that the resident would frequently use the identified intervention during the night.

Administrator #100 said that the home completed an investigation of the incident. The investigation determined that PSW #125 failed to provide resident #018 with the identified intervention, on a specified date, and acknowledged their error.

The licensee failed to ensure that resident #018 had identified interventions as specified in their plan of care. [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 the are set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to report the results of their investigations related to alleged abuse.

Ontario Regulation 79/10, s. 104 (2) states that the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. If not everything required in the report can be provided within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

A) Four critical incident reports (CI's) related to alleged abuse by residents #004 and #013 towards residents #005, #007, #008, #011 #012 were reported to the Ministry of Long-Term Care (MLTC).

The home's records identified that a review of the incidents was completed, and the allegations were unfounded; however, there was no documentation related to the outcome of the investigation. The CI to the Director was not amended.

The Administrator stated that the information related to these incidents was contained within the CI. They also acknowledged that the results of the alleged abuse were not reported to the Director.

B) A CI was reported to the MLTC related to an incident of alleged neglect. There was no amendment completed to the critical incident report.

The CI documented that PSW #125 did not provide resident #018 with an identified intervention on two occasions and that an investigation was being completed. The CI documented that immediate actions to the incident included completing an investigation. However, the results of the investigation were not reported to the Director.

The licensee failed to ensure that the results of the investigation into the alleged incident of neglect was reported to the Director.

C) A CI was submitted to the MLTC, related to alleged staff to resident emotional abuse. The CI documented that an allegation of emotional abuse was made and that the home was completing an investigation. It documented that immediate action was taken as the resident received the required care following the incident. The amended CI documented the results of the investigation but was not updated within the 10 days of the initial report.

The results of the investigation were not reported to the Director within 10 days of the original CI report.

The licensee failed to ensure that the results of the investigations were reported to the Director. [s. 23. (2)]

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 the results of the home's investigations related to alleged abuse are reported, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

The licensee has failed to ensure that all staff at the home have received training as required by this section.

Critical incidents related to alleged abuse were submitted to the MLTC.

A) LTCHA 2007, c. 8, s. 76 (2) states that the licensee shall ensure that prior to any person performing responsibilities in the home, the licensee is responsible to ensure that training is provided related to the following: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities; and, any other areas provided for in the regulations.

i) PTA #108 said that they had not been provided training from the home related to the home's policy on prevention of abuse and neglect. They said they received training from the company that employs them but it did not include the home's specific policy. PTA #108 said they were contracted to work in the home.

The home was unable to provide any training records for their initial orientation. The home's document titled "Yearly Checklist Contracted Service Provider", documented that they received training related to the resident's bill of rights, emergency procedures, and fire prevention and safety. The checklist did not document that PTA #108 received training on orientation related to the long-term care home's mission statement, the home's policy to promote zero tolerance of

abuse and neglect, the duty under section 24 to make mandatory reports and the protections afforded in section 26, the long-term care home's policy to minimize the restraining of resident's, infection prevention and control, acts, regulations, and policies of the home.

Administrator #100 said that they were unable to provide documentation of training for PTA #108 on orientation.

ii) Nutrition Manager #120 said that RD #141 had been working at the home for an identified time period. They believed that RD #141 attended annual training provided by the home; however, they were unable to provide documentation related to their attendance.

RD #141 said that they knew what was expected. Nutrition Manager #120 was unable to provide documentation to support orientation training of RD #141, who was a contracted staff member working in the home.

iii) PT #137 started working as a contracted employee in the home on an identified date.

The home's document titled "Yearly Checklist Contracted Service Provider", dated 2018, documented that they received training related to the resident's bill of rights, emergency procedures, and fire prevention and safety. The checklist did not document that PT #137 received training on orientation related to the long-term care home's mission statement, the home's policy to promote zero tolerance of abuse and neglect, the duty under section 24 to make mandatory reports and the protections afforded in section 26, the long-term care home's policy to minimize the restraining of resident's, infection prevention and control, acts, regulations, and policies of the home.

Administrator #100 said that they were unaware of the training that contracted employees received on orientation.

The licensee failed to ensure that PTA #108, RD #141, and PT #137, received training on orientation as required by this section.

B) LTCHA, 2007, c. 8, s. 76 (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following

paragraphs, at times or at intervals provided for in the regulations including: abuse recognition and prevention; mental health issues, including caring for persons with dementia; behaviour management; how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations; palliative care; any other areas provided for in the regulations.
O Reg. 221. (1)(2)(3)(4) stated that staff must receive annual training in all these areas and identified the additional training requirements for all staff.

The home was unable to provide documentation to support annual training in the identified areas for RD #131, PTA #108, and PT #137, who were contracted employees of the home that provide direct care to residents.

PTA #108 said that they received training from the company that they were contracted with but did not receive training directly from the home.

Recreation and Leisure Manager #118 said that they are responsible for the PT and PTA's education and training. They said that their annual training did not include the areas identified.

Nutrition Manager #141 said that there was no documentation to support the annual training of RD #141 for the areas identified.

Administrator #100 said that they were unaware of the training provided to their contracted employees. They said that they did not have documentation to support annual training in the identified areas but planned on developing a new system related to training of contracted employees.

The licensee has failed to ensure that all contracted staff at the home received training as required before they worked at the home and annually thereafter as set forth in the Act and regulations. [s. 76. (1)]

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 all staff at the home receive training as required by the Act and Regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop and implement an orientation program for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77; 2017, c. 25, Sched. 5, s. 19.

Findings/Faits saillants :

The licensee has failed to ensure that every volunteer received the orientation provided for in section 77 of the Act.

Section 77 of the LTCHA, stated that volunteers should receive information on orientation that includes: the residents bill of rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; fire safety and universal infection control practices; any other areas provided for in the regulations; and the protections afforded by section 26.

Section 223(2) of Ontario Regulation 79/10, stated that volunteers are to be provided with information related to the following: 1) residents safety, including information related to reporting incidents, accidents, and missing residents, and information on wheelchair safety; 2) emergency evacuation procedures; 3) escorting residents; 4) mealtime assistance, if the volunteer is to provide such

assistance; 5) communication techniques to meet the needs of the resident; 6) techniques and approaches to respond to the needs of residents with responsive behaviours.

Two volunteers did not receive training on orientation as required.

i) Volunteer #121 started volunteering in the home on an identified date. The home's documentation included a document titled "Volunteer Orientation Checklist". The checklist documented that they received training related to the home's policy to promote zero tolerance of abuse and neglect of residents on an identified date, after they were involved in an alleged incident of abuse.

Recreation and Leisure Manager #118 said that they did not receive training related to the home's policy to promote zero tolerance of abuse and neglect until after they began volunteering in the home.

ii) Volunteer #145 began volunteering in the home on an identified date. The home was unable to provide documentation to support that they received orientation training. Recreation and Leisure Manager #118 said that the home's orientation for volunteers was recently updated and they were unsure what training volunteer #145 had received.

Volunteers #135 and #136 said that they thought that volunteers were provided with more training now than when they began volunteering in the home. They said they were aware of what to do and what not to do.

The licensee failed to ensure that volunteer #121 and #145 received orientation training as required. [s. 77.]

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 the home's orientation for volunteers includes the required information as set out in the Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

This inspection was completed as follow-up to compliance order #001 from inspection 2018_750539_0006 issued on October 10, 2018, with a compliance date of February 8, 2019. The following incidents occurred prior to the compliance due date.

The licensee has failed to protect resident #030 from abuse by staff.

O. Reg. 79/10 states that emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. O. Reg. 79/10 states that verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A CI was submitted to the MLTC that reported an allegation of verbal and emotional abuse. The CI stated that PSW #115 was overheard telling resident #030 in a loud aggressive tone that they would not provide an identified care for the resident because of a behaviour they exhibited.

The plan of care for resident #030 provided direction to staff to assist with specified behaviours.

The home's investigation records included statements from two PSWs that witnessed PSW #115 yelling at resident #030 and overheard PSW #115 state they would never provide an identified care for the resident due to behaviours that they were exhibiting.

PSW #131 stated they considered the incident to be abuse and resident #030 seemed to be demonstrating an increase in an identified behaviour following the incident.

Administrator #100 stated that the home's investigation determined the incident to be verbal abuse.

The licensee has failed to protect resident #030 from abuse by PSW #115. [s. 19. (1)]

WN #9: 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:

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

Findings/Faits saillants :

This inspection was completed as follow-up to compliance order #003 from inspection 2018_750539_0006 issued on October 10, 2018, with a compliance date of February 8, 2019. The following incidents occurred prior to the compliance due date.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Administrator #100 said that they were to report incidents of alleged, witnessed, or suspected abuse immediately to the Director.

A) A CI was submitted to the MLTC that documented an allegation of verbal abuse towards resident #029. The CI and call to the after hours pager were not submitted to the MLTC until five days later.

The home's investigation records and email correspondence documented that PSW #122 reported alleged staff to resident verbal abuse by email to Administrator #100, former DOC #107, and RPN #103.

B) A CI was submitted to the MLTC that reported alleged staff to resident emotional abuse. The CI documented PSW #111 was unsure of the exact date the the incident occurred.

PSW #111 reported the incident in an email two or three days following the incident. The e-mail was sent to Administrator #100 and former DOC #107.

Administrator #100 stated that the home knew about the incident the day the email was sent, and acknowledged the home did not submit the CI to the MOLTC until almost 23 days later.

C) A CI was submitted related to an incident of alleged abuse. The CI documented that resident #014 was yelling inappropriate comments at residents #020, #017, #016, and #005.

Administrator #100 said that in this instance they were unsure why it was not reported as required.

D) A CI was submitted related to an incident of alleged incident of resident to resident sexual abuse.

Administrator #100 said that this incident was not reported immediately, as required.

The licensee failed to ensure that incidents of alleged, witnessed, or suspected abuse were reported to the Director immediately. [s. 24. (1)]

Issued on this 29th day of July, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MARIA MCGILL (728) - (A1)
Inspection No. / No de l'inspection :	2019_755728_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013175-18, 020997-18, 021730-18, 024066-18, 025040-18, 027474-18, 027619-18, 027791-18, 028601-18, 028993-18, 029107-18, 029406-18, 029952-18, 030924-18, 030925-18, 030926-18, 030927-18, 001366-19, 004585-19, 005186-19, 007401-19, 008057-19, 010637-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019(A1)
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Gateway Haven Long Term Care Home 671 Frank Street, P.O. Box 10, WIARTON, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tolleen Parkin

To Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_723606_0024, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA, 2007.

Specifically, the licensee must:
a) ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order # 001 from inspection 2018_723606_0024 issued on January 16, 2019, with a compliance date of May 16, 2019. The licensee was ordered to be compliant with s. 8(3) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was

on duty and present in the home at all times, except as provided for in the regulations.

A review of the home's staffing schedules from May 16 to June 10, 2019, identified that nine percent of RN shifts did not have an RN on duty and present in the home.

RPN #104 said that there were occasions after May 16, 2019, where they were the only registered staff in the building.

RN #105 said that there was no RN in the home for night shift on June 6, 2019, and a registered staff shortage occurred on June 1 and 2, 2019.

Administrator #100 said that the home has not been able to fill the RN staffing complement and an RN was not on duty and present in the home for seven shifts between May 16 to June 10, 2019.

The home failed to ensure that they had an RN that was an employee of the licensee was on duty and present in the home nine percent of the time from May 16 to June 10, 2019.

The severity of this issue was determined to be a level 2 as there was risk of harm to residents. The scope of the issue was a level 3 as it impacts all residents in the home. The home had a level 5 history as they had on-going non-compliance and four of more compliance orders that included:
- compliance order (CO) issued January 16, 2019, with a compliance due date of May 16, 2019 (2018_723606_0024)
- voluntary plan of correction (VPC) issued October 10, 2018 (2018_750539_0006).
(735)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_750539_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:
a) ensure that staff report incidents of alleged, witnessed, or suspected abuse immediately as per the home's policy to promote zero tolerance of abuse and neglect.
b) ensure that registered staff #129 is educated on the home's procedure related to reporting. The completed education should be documented and filed in the home.

Grounds / Motifs :

(A1)
1. The licensee has failed to comply with compliance order #002 from inspection 2018_750539_0006 issued on October 10, 2018, with a compliance date of February 8, 2019.

The licensee was ordered to be compliant with s. 20(1) of the LTCHA.

Specifically, the licensee shall ensure:
1. The procedures within the policy for investigating alleged, suspected or witnessed abuse and neglect of residents are complied with.

The licensee completed step one in the order; however, the licensee was not compliant with s. 20 (1) of the LTCHA, 2007.
The home's zero tolerance of abuse and neglect policy, titled Prevention of Abuse & Neglect of a Resident, last revised January 2019, directed registered staff to immediately report any incidents to the Director of the Ministry of Long-term Care through the Administrator or DOC by phone call.

A CI was submitted to the MLTC two days following an incident of alleged visitor to resident abuse.

PSW #125 said that they reported the incident to RPN #129. RPN #129 did not report the incident to management. No relevant progress notes were noted in the resident's chart on this date.

RN #123 said that two days following the incident, they overheard staff discussing the incident and reported it to management.

Administrator #100 said that staff were to report incidents of alleged abuse immediately to the Administrator or DOC by phone call. They said that they were in the building at the time of the incident and it was not reported to them or the DOC as required by the home's policy. They said they became aware of the incident, two days later, after receiving a phone call from RN #123.

The licensee failed to ensure that staff reported the incident of alleged abuse of resident #005 immediately, as required by the home's policy to promote zero tolerance of abuse and neglect.

The severity of this issue was determined to be a level 1 as there was no harm to the residents. The scope of the issue was a level 1 as it related to 1 of the 5 instances reviewed. The home had a level 5 history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
- CO #002 issued October 18, 2018, with a compliance due date (CDD) of February 8, 2019 (2018_750739_0006);
- CO #002, issued November 9, 2018, with a CDD of December 29, 2018 (2017_610633_0015).
(728)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 09, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MARIA MCGILL (728) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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Service Area Office / Bureau régional de services : Central West Service Area Office