



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_0018, 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 information provided on the Critical Incident.
The following Inspection Protocols were used during this inspection:
Critical Incident Response
Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend, Legendé. Lists abbreviations for WN, VPC, DR, CO, WAO in both English and French.

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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Sept 26, 2011 - 13:41 - Missing drug identified on July 5/11 and not reported through a Critical Incident until July 15/11.

Issued on this 26th day of September, 2011

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

Elizabeth Elrudge