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 9, 2021	2021_796754_0017	001969-21, 002242-21, 003204-21, 008374-21	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): May 26, 27, 31, June 1, 2, 3, 4, 2021.

The following intakes were completed during this Critical Incident inspection:
Log #001969-21, related to an allegation of physical abuse,
Log #003204-21, related to an allegation of physical abuse,
Log #002242-21, related to allegations of rough care, and
Log #008374-21, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI-Coordinator/ Continence Lead, Registered Practical Nurses (RPNs), Behavioral Support Lead/RPN, Personal Support Workers (PSWs), and a Resident Support Aid.

The inspector also toured the home, observed resident and staff interactions and meal services, reviewed relevant clinical records, the home's related policies and documentation and completed staff and resident interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 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 :

1. The licensee failed to immediately report an allegation of physical abuse of a resident to the Director in accordance with s. 24 (1) 2 of the Long-Term Care Homes Act. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with s. 24 (1).

PSW #107 said they had concerns with alleged physical abuse of a resident however they did not report it to management at the home until four days later.

The Director of Care (DOC) and Administrator said they first submitted the Critical Incident System (CIS) four days after the alleged physical abuse.

By not reporting the incident of alleged physical abuse of a resident to the Director immediately, the Director was unable to respond to the allegation immediately.

Sources: CIS Report, Interview with the Administrator, DOC, and PSW #107. [s. 24. (1)]

Issued on this 10th day of June, 2021

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

Original report signed by the inspector.