Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: January 24, 2024	
Inspection Number: 2024-1548-0001	
Inspection Type: Critical Incident	
Licensee: Corporation of the County of Bruce	
Long Term Care Home and City: Gateway Haven Long Term Care Home, Wiarton	
Lead Inspector Katy Harrison (766)	Inspector Digital Signature Kathryn Harrison Digitally signed by Kathryn Harrison Date: 2024.01.24 15:40:04 -05'00'
Additional Inspector(s) Tanya Murray (000735)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15, 16, 17, 18, 2024

The following intake(s) were inspected:

- Intake: #00097193, related to the unexpected death of a resident
- Intake: #00104179, related to neglect
- Intake: #00105722, related to a disease outbreak. The following intakes were completed in this inspection: Intake: #00102333, and Intake: #00102674, both were related to a disease outbreak

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable;

The licensee has failed to ensure that continence care and sufficient changes was provided to residents to ensure they remain clean, dry and comfortable.

Rationale and Summary
Multiple residents were found heavily soiled at the beginning of the day shift.

Multiple residents stated they had not received any care during the night shift.

Failure to provide continence care to residents could lead to skin breakdown and discomfort.

Sources:
Clinical records, interviews with residents and staff [000735]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of a disease outbreak on two units in the home on January 2, 2024.

Rationale and Summary

Grey Bruce Public Health Unit declared two enteric outbreaks on January 2, 2024, on 3 East and 3 West units.

The Director was informed on January 4, 2024. The Administrator confirmed the outbreaks were not reported immediately, as required.

The home's failure to immediately report the incident to the Director may have delayed follow up by the Ministry of Long-Term Care.

Sources: Review of Critical Incident System Reports, interview with the Administrator. [766]