Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 6, 2023	
Inspection Number: 2023-1163-0005	
Inspection Type: Critical Incident	
Licensee: Bay Haven Nursing Home Incorporated	
Long Term Care Home and City: Bay Haven Nursing Home, Collingwood	
Lead Inspector Tanya Murray (000735)	**Inspector Digital Signature**
Additional Inspector(s) Jessica Bertrand (722734)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25-27, 30-31, 2023

The following intake(s) were inspected:
- Intake: #00093945, CI #2657-000013-23 related to fall prevention and management

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

The licensee has failed to comply with their procedures to reduce risk after a resident had a fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there was a written description of the program that includes relevant policies, procedures and protocols and provides for methods to reduce risk and must be complied with.

Specifically, the licensee did not comply with the policy "Fall Prevention and Management" dated 2021, which was included in the licensee's Fall Prevention Program.

Rationale and Summary
The home's fall prevention and management policy stated that if there was a significant change following a fall, physiotherapy (PT) would complete a mobility assessment and make recommendations to the nursing staff. Nursing staff would update the Care Plan and communicate to all staff of any changes. This was not completed after a resident had a fall that resulted in a significant change in status.

A resident had a fall that lead to a change in condition.

A referral was sent to physiotherapy multiple times for various mobility and transfer status concerns within a month period. There were no assessments documented during this time period related to the resident's change in status.

The DOC confirmed that there had not been an assessment completed when the resident had a change in condition after a fall to reassess their transfer status.

When the resident was not assessed after their fall and subsequent change in status, staff may have used improper transferring techniques for the resident.

Sources: Clinical records, interview with staff, home's fall prevention and management policy. [000735]

WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the critical incident was submitted to the Director within one business day after a resident had a fall that caused an injury for which they were taken to hospital and caused a significant change in the resident's health condition.

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Rationale and Summary
The resident had a fall and was sent to the hospital. The following day, a registered nurse (RN) was informed by the power of attorney that the resident had been admitted with an injury and required surgery.

The critical incident was not reported to the Director until several days.

Sources: Clinical records, interview and critical incident report. [000735]