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

Public Report

Report Issue Date: April 2, 2025
Inspection Number: 2025-1163-0001
Inspection Type: Critical Incident
Licensee: Bay Haven Nursing Home Incorporated
Long Term Care Home and City: Bay Haven Nursing Home, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 25 - 27, 31, 2025 and April 1, 2, 2025
The following intake(s) were inspected:

- Intake: #00135948, CI#2657-000016-24 – related to unwitnessed fall with injury
- Intake: #00138972, CI#2657-000001-25 – related to ARI COVID Outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to comply with the falls prevention and management program when a falls intervention was not functioning at the time when the resident fell.

Sources: care plan, progress note, interview with staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A. The licensee has failed to ensure that the Standard issued by the Director related to Infection Prevention and Control (IPAC) was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with related to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 9.1 (f) indicated additional personal protective equipment (PPE) requirements including appropriate selection application, removal and

disposal.

Several staff did not wear a gown when they cared for a resident, who was on additional precautions.

Sources: Inspector observations, progress note, interview with staff

B. The licensee has failed to ensure that the Standard issued by the Director related to Infection Prevention and Control (IPAC) was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with related to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 9.1 (f) indicated additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal.

A resident was on additional precautions. A staff member did not wear a gown when they cleaned the resident's room and their washroom.

Sources: Inspector observations, care plan, interview with staff

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 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 has failed to ensure that a critical incident was immediately reported to the Director.

Source: CIS report, meeting minutes, interview with staff