Ontario

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

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
Central.west.SAO@ontario.ca

Original Public Report

Report Issue Date: November 1, 2022	
Inspection Number: 2022-1163-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Bay Haven Nursing Home Incorporated	
Long Term Care Home and City: Bay Haven Nursing Home, Collingwood	
Lead Inspector Kim Byberg (729)	**Inspector Digital Signature** Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2022.11.09 10:52:41 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 13, 14, 17-20, and 24, 2022

The following intake(s) were inspected during this Critical Incident (CI) inspection:

- Intake: #00001784, related to an allegation of abuse towards a resident

The following intake(s) were inspected during this Complaint inspection:

- Intake: #00008439-related to infection prevention and control practices (IPAC)

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

Prevention of Abuse and Neglect
Infection Prevention and Control
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Binding on licensees

Non-compliance with: FLTCA, 2021 s. 184(3)

The licensee has failed to ensure every operational or policy directive that applied to the long-term care home was complied with in relation to COVID-19 asymptomatic screen testing of staff.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, was followed.

The COVID-19 guidance document as of June 11, 2022, stated that where a staff member takes an antigen test at the long-term care home, the test must be taken as soon as possible after beginning a shift, and the individual may enter the home with appropriate personal protective equipment (PPE) and following IPAC practices while waiting for the test results. Staff should not provide direct care to residents until a negative test result was received.

Rationale and Summary

A staff member reported for their shift and performed a rapid antigen test (RAT). They did not wait to receive their test results before providing direct care to residents. One hour later the RAT result was observed to be positive for covid-19.

The home's policy titled "COVID-19 Asymptomatic Screen Testing" revised June 6, 2022, stated that staff, students, and volunteers should not provide direct care until a negative test result was received.

The Director of Care (DOC) stated that the staff member should have obtained their test result prior to providing care to residents and if they had tested positive, they should have left the home immediately.

By not checking RAT results prior to providing direct care to residents, it could have resulted in the transmission of COVID-19 to residents.

Sources: Interview with the DOC, record review of the home's RAT log, the home's policy "COVID-19

Asymptomatic Screen Testing" revised June 6, 2022, the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 Guidance Document for Long-Term Care Homes in Ontario as of June 11, 2022.

[729]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abused by a staff member.

"Physical abuse" is defined as, the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg 246/22, s. 2. (1).

Rational and Summary

A staff member assisted a resident with morning care. After care was completed the staff member told their co-worker that the resident had been feisty while care was provided.

When the resident exited their room with the staff member a second staff member noted the resident's face was red and blotchy and they thought the resident had been crying. A short time later a registered staff observed bruising on multiple areas of the resident's body, and within an hour the bruising had worsened

The Medical Director of the home that had additional qualifications as an investigating coroner and was familiar with defensive/offensive injuries completed an assessment of the resident. They stated that the injuries were not a result of defense but were consistent with being forcibly grabbed.

By not ensuring the resident was protected from abuse by a staff member, the resident sustained bruising to multiple areas of their body.

Sources: Interview with PSW's, RPN's, and the DOC. Record review of the home's investigation notes, written statements from PSW's, documentation of voicemail from police officer, prevention of abuse and neglect of a resident checklist, point of care (POC) response history for responsive behaviours, documentation in POC, skin and wound assessments, plan of care for the resident, surge learning and orientation checklist of education specific to prevention of abuse and responsive behaviours, resident care assignments and schedule, risk management report, policy titled responsive behaviours program,

reviewed June, 2022, policy titled zero tolerance of resident abuse and neglect updated May 2019, and employee files.

[729]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that when a resident exhibited impaired skin integrity, they were assessed weekly by a registered nursing staff member.

Rationale and Summary

A resident was identified to have impaired skin integrity. There were no weekly skin and wound assessments completed for three consecutive weeks.

The home's skin and wound care lead stated that weekly assessments should have been completed until the residents' impaired skin integrity was healed.

When the home did not complete weekly assessments of the residents impaired skin integrity, the risk of complications related to the impaired skin integrity may not have been identified and treatment initiated immediately.

Sources: Review of the residents' progress notes, skin and wound care application, assessments in point click care, electronic treatment administration record (eTAR), plan of care, and the "Skin and Wound Program Policy" last reviewed 05/18/2022, and interview with an RPN, RN and clinical nurse manager, and DOC.

[729]

Ontario

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

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
Central.west.SAO@ontario.ca