

**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:** October 1, 2025

**Inspection Number:** 2025-1163-0003

**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): September 22, 24, 25, 29, 2025 and October 1, 2025.

The following intake(s) were inspected:

-Intake: #00155236 - Falls prevention and management.

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

Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to protect

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

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from neglect by a staff member.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A resident fell and sustained an injury. Assessments were not completed as required and the physician was not notified of the resident's condition right away. The Director of Nursing acknowledged that the physician and family should have been informed immediately for further action.

The lack of immediate action taken potentially jeopardized the resident's health and the need for further medical intervention to be initiated.

Sources: Resident's progress notes and assessments, Interviews with Director of Nursing, PSW, ADOC, and RPN.