Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 19, 2015	2015_378116_0014	T2392-15/007784-15	Complaint

Licensee/Titulaire de permis

HAROLD AND GRACE BAKER CENTRE
1 NORTHWESTERN AVENUE TORONTO ON M6M 2J7

Long-Term Care Home/Foyer de soins de longue durée

HAROLD AND GRACE BAKER CENTRE
1 NORTHWESTERN AVENUE TORONTO ON M6M 2J7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 30, August 4, 5, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), registered staff members, personal support workers (PSWs), visitors to the home and the substitute decision-maker of resident #001.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On an identified date,the bathing spa room located on an identified resident care area, was observed to be unlocked, unsupervised and kept open by a chair. Residents were observed to be in the corridor and in close proximity to the spa room. The floor surrounding the tub was observed to be wet and posed a slip hazard to residents. Resident care equipment was observed to be stored in the spa room along with a pair of wheelchair footrests that were on the floor. The imperial surgical blanket warming system was observed to be in use and noted to have an interior temp of 46.3. A warning sign imprinted on the warming system states the following " patient burn hazard-temperature of cabinet contents may differ from display temperature".

Interviews held with identified staff members revealed that the spa room door is kept open due to the ventilation system however, it should be locked. Further interviews held with the Director of Care (DOC) and the Executive Director (E.D.) confirmed that the spa room door should be kept closed and locked at all times when not in use. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The written plan of care for an identified resident indicates that the resident requires total assistance for all toileting needs due to impaired cognition. The resident is to be transferred to bed for peri-care and incontinence product changes provided as specified.

An interview with an identified staff member revealed that on an identified date, there was no assistance available to transfer and change the resident who required continence care. The PSW had knowledge of the resident's toileting requirements however, due to a staff shortage the identified staff member was unable to render continence care to the resident as specified in the written plan of care. The identified resident received a continence change close to the end of the identified shift.

Interviews held with the DOC and the E.D. confirmed that the identified resident did not receive continence care as specified in the plan. [s. 6. (7)]

2. The written plan of care for an identified resident indicates that the resident requires support for all transfers and requires two staff full support to transfer safely with a mechanical lift.

On an identified date, the inspector observed the private duty service provider of the resident request the assistance of an unassigned PSW to transfer the resident. The PSW queried to the private duty service provider of which mechanical lift to use of which, the private provider pointed to a specific mechanical lift. An interview held with the PSW revealed that the private duty service provider transfers the resident frequently and at times may not request for assistance from staff.

Further interviews held with the DOC and E.D. confirmed that as per the homes guidelines, external private duty service providers are prohibited in transferring residents and the transferring requirements for the identified resident were not provided as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report in writing was sent to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes: a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

On an identified date, the identified resident sustained an injury of unknown etiology. Upon discovery, an assessment was conducted and the physician and POA were notified. The resident was transferred to the hospital for further assessment and returned to the home.

Review of the health record revealed and interviews held with identified staff members and members of management confirmed, that the licensee failed to submit a report in writing to the Director of an incident that resulted in injury of the identified resident. [s. 107. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a report in writing was sent to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes: a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the complaint that cannot be investigated and resolved within 10 business days, an acknowledgement was provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response made to the complainant as soon as possible in the circumstances.

On an identified date, an identified resident sustained an injury of unknown etiology. The resident was transferred to the hospital and returned to the home. On the established date of the injury, the substitute decision-maker (SDM) of the resident inquired on how the resident acquired the injury and was informed that the incident was under investigation.

On an established date, the substitute decision-maker (SDM) of the identified resident sent an electronic mail (e-mail) to the attention of the DOC requesting an update on the investigation to which; the DOC responded informing the SDM that the investigation will require a few more days for completion. The SDM sent a subsequent e-mail correspondence to the DOC and copied the E.D. 14 days after, inquiring about the status of the investigation.

Interviews held with members of the management team confirmed that a date by which the complainant can reasonably expect a resolution were not provided and due to scheduling, a follow-up response was not made to the complainant as soon as possible in the circumstance. [s. 101. (1) 2.]

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Issued on this 19th day of August, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.