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
Jan 27, 2016	2015_219211_0025	035667-15	Resident Quality Inspection

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

JOELLE TAILLEFER (211), CECILIA FULTON (618), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 22, 23, 24, 29, 30, 31, 2015, January 4, 5, 6, 7, 2016.

During the course of the inspection critical incident Log #026861-15 and complaint Log #000977-15 were completed.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Programs Manager (PM), Food Services Manager (FSM), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Worker (FSW), family members and residents.

During the course of the inspection, the inspectors conducted a tour of the home including resident home areas, conducted a dining observation, medication administration observation, observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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During the course of this inspection, Non-Compliances were issued.

5 WN(s)
2 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 was a safe and secure environment for its residents.

On December 23, 2015, at 0730 hours the door to the bathing spa room located on C wing was unlocked.

Interview held with Personal Support Worker (PSW) #102 stated that the door should be locked at all times and that they changed the lock yesterday; however the door was still not closing properly.

The Director of Care (DOC) confirmed that they are having difficulties with the door latching and disconnected the imperial warming unit after the inspector brought it to the home's attention. [s. 5.]

2. On January 5, 2016, the inspectors observed that windows in two identified rooms could be removed with minimum effort. The inspectors observed both windows were exterior windows with screens.

This situation was brought to the attention of the Executive Director (ED), and the Environmental Services Manager (ESM), who confirmed the inspector's findings and further observed that windows in four additional rooms were easily removable and presented a potential safety risk to residents. ESM revealed that all of the windows in the home were the same type and could be easily removed and pose a risk to resident's safety. ED and ESM stated that repairs would begin on January 6, 2016.

On January 6, 2016 the inspector observed repairs being done on the windows. [s. 5.]

3. On December 22, 2015, the inspector observed four screws sticking out of a hand sanitizer dispenser bracket located on the hallway's hand rail beside room #110.

On December 22, 2015, interview with PSW #104 revealed that the hand sanitizer dispenser bracket was broken and was out of the wall. The PSW proceeded to state the broken hand sanitizer dispenser bracket should not have been left on the hallway hand rail and the exposed screws posed a safety issue for the residents. The PSW stated that the end of the four screws were sharp enough to puncture a resident's skin. The PSW #104 removed the broken hand sanitizer dispenser bracket from the hallway hand rail.

On December 23, 2015, interview with the ESM revealed he/she was not aware of the broken hand sanitizer dispenser bracket and the staff needs to follow the home's maintenance process by completing a requisition titled "Physical Plant Service Requisition". The EMS confirmed that the broken hand sanitizer dispenser bracket with the screws exposed could have been a safety issue. [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 safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including the following:
1.All areas where drugs were stored shall be kept locked at all times, when not in use.

On January 5, 2016, at 1310 hours, this inspector observed an unattended medication cart sitting beside an identified nursing station to be unlocked and the inspector was able to open the drawers of the medication cart.

RN #119 confirmed that the medication cart was unlocked and was accessible to anyone passing by and that it should have been locked when unattended.

Interview with the DOC confirmed that medication cart is to be locked at all times when not in use. [s. 130. 1.]

2. On January 6, 2015, at 0855 hours, this inspector observed an unattended medication cart to be stored outside of the nursing station on an identified home area. The medication cart was left unlocked as this inspector was able to open the drawers of the medication cart.

RPN #125 and ADOC confirmed that the medication cart was unlocked and was accessible to anyone passing by and did not keep the medication cart locked when not in use.

Interview with the DOC confirmed that medication cart is to be locked at all times when not in use. [s. 130. 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 the security of the drug supply, including the following:
1.All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date, resident #013 approached the inspector requesting time to discuss an issue.

Interview with resident #013 revealed that RPN #124 had spoken to them in a disrespectful manner.

Resident stated that they felt disrespected and angered by these comments.

Resident revealed that they reported the incident to PSW #121 later on the same shift.

Interview with PSW #121 revealed that the resident had reported the incident to them and that the resident was upset by the incident. PSW #121 revealed that they had not reported the incident to the DOC as the resident stated that they would be reporting the incident themselves. PSW #121 did not follow up with anyone to confirm that the incident had been reported.

DOC confirmed that the above mentioned incident had been reported to them by the resident.

DOC confirmed that the incident as reported to them by the resident would be considered inappropriate and would not be respectful of the residents' right to be treated with respect and dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of the resident was fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date, a medication administration was observed for resident #015.

This inspector observed RN #114 administer the medication to resident #015. The medication was administered on an exposed area of the resident's body in public view of other residents.

Interview conducted with RN #114 confirmed he/she did not get resident #015's consent to administered the medication in the identified area and did not provide resident #015 with privacy during the administration of the medication.

Interview with the DOC confirmed staff is to administer treatment such as certain medication in a private location away from other residents and the public. [s. 3. (1) 8.]

WN #4: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The written plan of care for resident #007 indicated that the resident is to wear protective devices at all times.

Observation of the resident on three identified dates found resident sitting alone at his bedside without the protective devices on.

Interview with PSW #112 revealed that they were not aware that this care was to be provided and that the resident was not wearing the protective devices at the time of the interview.

Interviews with RPNs #111 and #110 revealed that they were aware of the contents of the care plan, however observation of the resident at the time of these interviews revealed the plan of care was not being provided as the resident was not wearing the protective devices.

Interview with DOC confirmed the resident should be receiving care as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of the written plan of care for three consecutive identified months and the current Kardex indicated resident #006 is on isolation precautions.

Interview with PSWs #127 and #128 revealed that the resident was not on isolation precautions during the above time periods and the instruction should have been removed from the resident's plan of care.

Interview with RPN #123 and the DOC confirmed that the resident was not on isolation precautions and the instructions in the plan of care should have been removed and updated when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home have instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

On an identified date, resident #013 approached the inspector requesting time to discuss an issue.

Interview with resident #013 revealed that RPN #124 had spoken to them in a disrespectful manner.

Resident stated that they felt disrespected and angered by the these comments. Resident revealed that they spoke with PSW #121 and told them about the incident.

Interview with PSW #121 revealed that the resident had reported to them that RPN #124 had spoken to the resident rudely, and that resident was upset by the incident.

PSW #121 revealed that they had not reported the incident to the DOC as the resident stated that they would be reporting the incident themselves. PSW #121 revealed that they did not follow up with anyone to confirm that the incident had been reported.

The home's policy section "Management of Concerns/Complaints/Compliments" index LP-B-20 under Verbal Concerns/Complaints dated October 2014, indicated the Customer Services Response Form (CSR) is to be completed in full and all actions taken during the investigation will be documented.

DOC confirmed that the above mentioned incident had been reported to them by the resident and revealed that PSW #121 had never reported the incident and the policy was not complied with. [s. 8. (1) (b)]

Issued on this 1st day of February, 2016

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

Original report signed by the inspector.