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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 22, 2016	2016_356618_0018	024634-16	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

CECILIA FULTON (618), 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): August 16, 17, 18, 19, 22, 23 and 24, 2016

During the course of this inspection the following Intake Logs were inspected: Log #s 006740-16, 023158-16, 023847-16, 024566-16.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Dietitian (RD), Physiotherapist (PT), Programs Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Residents' family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian (RD) completed a nutritional assessment for a resident when there was a significant change in the resident's health condition.

Record review revealed that upon return from a hospitalization resident #006 was weighed and it was determined they had lost considerable weight.

A referral was made to the RD to assess the resident's weight loss and to assess for a change in diet texture.

Review of the resident progress notes and interview with the RD revealed that they had assessed resident related to an identified condition. The RD revealed that during this visit they had a discussion about this identified issue and answered the families questions regarding food choices. No follow up regarding the continued weight loss was made during this meeting.

The resident was next weighed on and identified date in April 2016, and had a further significant weight loss over the previous month.

Record review did not reveal that there was any intervention undertaken by the staff or the RD in response to this significant weight loss.

Interview with the RD revealed that they were following the resident based on the post hospitalization referral. Interview with the RD revealed that their duties with regards to this referral would include continued monitoring and assessment of the resident's nutritional requirements, weight and intake.

Interview with RD and record review revealed that the RD next saw the resident in response to a referral related to another identified condition.

Interview with RD revealed that they had not assessed the resident's weight loss during this assessments.

Interview with the DOC revealed that the RD was expected to follow up with the resident and that they had not. [s. 26. (4) (a),s. 26. (4) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was who became incontinent received an assessment using a clinically appropriate assessment instrument specifically designed for assessment of incontinence.

Review of resident #004's Minimum Data Set (MDS) assessments revealed that under section H, continence assessment, the resident was coded a zero indicating that they are continent and have complete control of their bladder.

A subsequent quarterly MDS assessment coded this section as a three indicating that the resident is frequently incontinent, tended to be incontinent daily, but some control present. All subsequent MDS assessments for this resident were coded as frequently incontinent.

Review of the notes of a resident care conference revealed a discussion identifying that the resident is more incontinent than they were last year.

Record review and staff interview revealed that there was no continence assessment completed when this change in the resident's continence status was identified.

Interview with DOC confirmed that the MDS coding and the discussion at the care conference identified a change in the resident's continence status and that a continence assessment should have been conducted, but it was not. [s. 51. (2) (a)]

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:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed of the current status of an incident within 10 days of becoming aware of the incident.

The home submitted a Critical Incident System (CIS) report #2732-000001-14 on March 13, 2014, indicating disease outbreak of an enteric nature to the Ministry of Health and Long-Term Care (MOHLTC) Director. The CIS report indicated the enteric outbreak was on an identified home area with symptoms of diarrhea and vomiting involving six residents on the same wing. Once the CIS report was received, the Director had requested to amend the CI once the outbreak was declared over.

A review of the home's submitted CIS reports on the Ministry of Health and Long Term Care Homes Portal did not show that the report had been amended as requested by the Director.

An interview conducted with the Director of Care (DOC) confirmed the CIS report submitted on March 13, 2014, was not amended with the current status of the incident within 10 days. [s. 107. (4) 3. v.]

Issued on this 25th day of November, 2016

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

Original report signed by the inspector.