Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 4, 2019	2019_642698_0009	028387-17, 004639-18, 015254-18, 028144-18, 009224-19	Critical Incident System

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

ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 4-7, 11-14, 17-21, 2019.

Log # 015254-18, CIS #2732-000009-18 related to hospitalization and change in condition;
Log # 028387-17, CIS #2732-000035-17 related to responsive behaviors;
Log # 004639-18, CIS # 2732-000006-18 related to abuse;
Log # 009224-19, CIS #2732-000007-19 improper transfer and failure to follow-up.

Log # 028144-18, CIS #2732-000024-18 related to abuse was inspected under a concurrent complaint inspection # 2019_642698_0008.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Dietician (RD), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

During the course of this inspection, the inspector interviewed staff, observed resident and staff interactions, reviewed resident records, policies and video recordings.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System (CIS) # 2732-000007-19 submitted to the Ministry of Health (MOHLTC) on specified date regarding an injury, where resident #006 sustained an injury to an identified area of the body on day shift requiring interventions. The injury was discovered by the evening shift staff who reported it.

Record review of resident #006's care plan reflected them being at low risk for falls as evidenced by the fall risk screen. The care plan also reflected the use of a mechanical device with two-person assistance for transferring.

According to the home's investigation notes on an identified date, it was concluded that resident #006 may have sustained injuries during an improper transfer by PSW #109. The notes referred to video surveillance footage that showed PSW #109 entering and exiting the room with a mechanical lift. At the time the resident was brought out of the room via mobility device, there were no other staff entering or exiting the room. The home's investigation notes also verified that upon questioning of PSW #109, they could not give an account of who assisted them with the transfer of resident #006 from the bed. At the time of the investigation, several staff members were interviewed and confirmed that PSW #109 received assistance in returning the resident back to bed in the afternoon but no one assisted them with the transfer of resident #006 in the morning.

PSW #109 was not available for interview via telephone on several attempts. According to the home's current employee schedule on a specified date range, PSW #109 was slated to be on Leave of Absence (LOA) throughout that time period. This was confirmed by the staffing clerk on the unit during the inspection at the home.

Interview with RN #107 stated that on an identified date, PSW #109 informed them that resident #006 had a scratch on an identified area of their body earlier that morning. According to RN #107, upon assessment, there were no injuries noted on resident #106's on that particular area of their body. RN #107 confirmed that they did not follow-up with PSW #109 regarding the correct location of the injury.

During an interview with the Executive Director (ED) #102 on a speicified date, they confirmed that resident #006 required two person transfer with a mechanical lift and total care with all Activities of Daily Living (ADL). ED #102 also confirmed that a full investigation was conducted by the home and verified that an improper transfer was done by PSW #109 and failure to follow up by RN #107 occurred. ED #102 went on to say that there was no suspicion of a fall as there was no evidence of injury noted upon

assessment. They stated that both PSW #109 and RN #107 were disciplined as a result their actions. [s. 36.]

Issued on this 5th day of July, 2019

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

Original report signed by the inspector.