Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Apr 27, 2022	2022_846665_0005	010413-21, 012950-21, 020855-21	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

JOY IERACI (665)

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): March 21, 22, 24, 25, 28 and 29, 2022; Off Site March 30 and 31, 2022.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
Log #010413-21, CIS #2732-000005-21 related to falls;
Log # 012950-21, CIS #2732-000007-21 related to falls and;
Log #020855-21, CIS #2732-000012-21 related to improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Staff Educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Personal Support Assistants (PSAs), Housekeeping Staff and Family Members.

During the course of the inspection, the inspector/s observed the home's IPAC practices, observed provision of resident care and reviewed clinical records, IPAC audits and relevant home policies.

Inspector #589 was present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 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, staff and visitors.

Observations of the home's IPAC practices identified that two PSAs did not follow the instructions of the rapid antigen test (RAT) device on March 21 and 29, 2022. Two visitors were tested at the time of the observations.

The instructions of the RAT device indicated that the collected specimen swab be squeezed 10-15 times by compressing the walls of the extraction tube against the swab and, the swab with the collected specimen were to stand in the extraction tube solution for two minutes.

The IPAC Lead and Staff Educator indicated the home started to use a different brand of the RAT device about one month ago and the PSA's did not receive training on it's use.

The DOC stated the manufacturer's instructions were to be followed to ensure accuracy of the test results.

There was actual risk of harm to residents, staff and visitors related to not following the RAT device's instructions related to the accuracy of the test results.

Sources: IPAC observations on March 21 and 29, review of BTNX Rapid Response device's instructions and interviews with IPAC Lead, Staff Educator, DOC and other staff. [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. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no device provided for in the regulations was used to restrain a resident.

The home submitted a critical incident report related to a resident being restrained with a prohibited device to prevent a responsive behaviour.

A PSW indicated that the resident ambulated independently using a mobility device. At the start of their shift, they discovered the resident in the hallway with the restraint wrapped around the wheels of the device. The PSW stated the resident looked upset and was trying to ambulate unsuccessfully.

The home conducted an investigation and substantiated that another PSW used a prohibited device to restrain the resident.

There was actual risk of harm to the resident when the prohibited device was used to restrain the resident.

Sources: Review of CIS: 2732-000012-21 report, investigation notes, and interview with a PSW and other staff. [s. 35. (a)]

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 no device provided for in the regulations is used on a resident, (a) to restrain the resident; or (b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement, to be implemented voluntarily.

Issued on this 27th day of April, 2022

[redacted]

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

Original report signed by the inspector.