Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: March 28, 2023	
Inspection Number: 2023-1228-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Harold and Grace Baker Centre	
Long Term Care Home and City: Harold and Grace Baker Centre, Toronto	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature**
Additional Inspector(s) Atala Katel (000705) was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 16-17, 20-21, 2023.

The following intake(s) were inspected:

- Intake: #00020317 - related to a complaint regarding improper care.
- Intake: #00020874 - 2732-000004-23 - related to a fracture of unknown cause.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
On a number of consecutive dates, the resident was administered an as needed medication as an initial intervention to manage their pain, however these attempts only provided temporary relief and were ineffective as the resident continued to experience pain. The resident experienced a change in condition, and was eventually transferred to hospital on a specified date where they were found to have an injury.

The home's "Pain Assessment and Management" policy, last modified on April 4, 2022, indicated that a resident will be screened for pain when new or worsened pain is identified, including the use of as needed pain medication for three consecutive days, or with a change in condition, followed by the completion of a 72-hour monitoring and a comprehensive pain assessment. A review of the resident's clinical records indicated that there was no pain screening, monitoring, or assessment completed when they identified with pain.

Registered Nurse (RN) #102 acknowledged that a pain assessment was not completed and should have been when the resident presented with a new onset of pain and a change in condition. RN #102 and #109 both acknowledged that the home's "Pain Assessment and Symptom Management" policy was not complied with when the resident was administered as needed pain medication for a number of consecutive days and exhibited a change in condition. The Director of Care (DOC) stated that a pain assessment should have been completed for the resident, and the home's policy was not complied with.

There was a risk of worsening the resident's injury and not appropriately addressing their pain when a pain assessment was not completed by the staff.

Sources: Resident #001's clinical records, the home's internal investigation notes, "Pain Assessment and Management" policy (CARE8-O10.01), last modified on April 4, 2022, and interviews with RN #102 and #109, and DOC.

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WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day of an incident that caused injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary
A resident was transferred to hospital on a specified date, and on the following day, the home was initially informed of the resident's injury and the need for a medical intervention.

Director of Care (DOC) acknowledged that the home was aware of the resident's change in status and condition on one to two days after the resident's transfer to the hospital, and that the resident experienced a significant change.

The home did not submit a Critical Incident Report until the resident returned to the home, which was five business days after being aware of the resident's significant change in status.

Sources: Critical Incident Report #2732-000004-23, resident #001's progress notes, and interview with DOC.

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