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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: November 14, 2023
Inspection Number: 2023-1228-0003
Inspection Type: Critical Incident
Licensee: Harold and Grace Baker Centre
Long Term Care Home and City: Harold and Grace Baker Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Lisa Salonen Mackay (000761)	Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2023.11.15 14:14:26 -05'00'

Additional Inspector(s) Dorothy Afriyie (000709)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31 and November 1, 2, 3, 6, 2023

The following intake(s) were inspected:

- Intake: #00095243 / Critical Incident (CI) #2732-000016-23 related to falls prevention and management
- Intake: #00097947 / CI #2732-000021-23 related to neglect and abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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.

Rationale and Summary:
According to the resident's care plan, an identified device should have been in place as a falls prevention intervention.

The resident was observed in bed. Falls Lead confirmed that the identified device was not in use as per their care plan.

The Director of Care (DOC) acknowledged that staff failed to follow the resident's care plan when the identified device was not in use.

Failure to follow the resident's care plan put the resident at risk of injury.

Sources: Review of resident's clinical record, interviews with staff.
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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement a protocol issued by the Director with respect to infection prevention and control.

The license has failed to ensure that hand hygiene was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Requirements 9.1(d) under the IPAC Standard.

Rationale and Summary:
During observation the Personal Support Worker (PSW) failed to perform hand hygiene before and after coming into contact with the resident's environment.

IPAC Lead and DOC both acknowledged that the PSW should have performed hand hygiene before and after coming into contact with the resident's environment.

Failure to provide proper hand hygiene in between resident contact placed residents at risk of infection transmission.

Sources: Observations, review of IPAC Standard and interviews with staff.
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