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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 4, 2024

Inspection Number: 2024-1228-0001

Inspection Type:
Complaint
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**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2024.04.18 21:06:09 -04'00'

Additional Inspector(s)
Faresha Mohammed (000825) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 19, 20, 21, 22, 25, 2024

The following intake was inspected in the Critical Incident System (CIS) Inspection:

- Intake #00105750/CI#2732-000002-24 was related to a disease outbreak.

The following intake was inspected in the Complaint Inspection:

- Intake #00108051 was related to a resident's care.

The following intakes were completed in the CIS Inspection:

- Intake #00105210/CI#2732-000031-23, intake #00105749/CI#2732-000001-24, intake #00107814/CI2732-000003-24 and intake #00108444/CI#2732-000005-24 were related to disease outbreaks.

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

Infection Prevention and Control

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 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care for a resident when they had a change in health status.

Rationale and Summary

The resident's clinical records revealed that the resident had a change in their health condition. The staff monitored the resident during their change in health condition; however, they failed to inform/call the resident's attending physician and did not

utilize on-call doctors services. The resident was assessed on a specified date by their attending physician during weekly rounds six days later after the resident had a change in their condition.

The physician acknowledged that they expected staff to call them when a resident had a change in their health condition including onset of new symptoms and change in their level of consciousness.

The Registered Nurse (RN) verified that the resident had a change in their health condition and the physician should have been contacted in a timely manner based on the resident's condition, however the physician was not notified/called by staff on any shift. The Associate Director of Care (ADOC) acknowledged that there was a change in resident's health status on a specified date, and registered staff failed to inform/call the physician about the resident's condition.

Failing to collaborate with the physician when the resident's health condition changed increased the risk of delayed treatment and interventions.

Sources: Resident's clinical records, interviews with physician, RN and ADOC.

[741673]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with their nutritional care and hydration program related to a dietary referral.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the nutritional care and hydration program included implementation of policies and procedures relating to nutritional care and dietary services and hydration and must be complied with.

Specifically, staff did not comply with the licensee home's policy "Food and Fluid Intake Monitoring" #CARE7-0.10.02 last revised March 2021, when a dietitian referral was not sent after a resident had a decline in intake.

Rationale and Summary
A resident was diagnosed with a medical condition and had a decline in intake.

The home's "Food and Fluid Intake Monitoring" policy directed staff to refer to the Registered Dietitian (RD) if a resident had a change in their usual intake.

Review of a resident's clinical records indicated that a dietician referral form was not sent to the RD for assessment as per the home's policy.

The Registered Practical Nurse (RPN), RN, and ADOC confirmed that a RD referral was not sent after the resident had a decline in intake, and a referral should have been completed.

Failure to send a RD referral after a resident had a decline in intake increased the risk of further decline if the root cause was not identified through an RD assessment.

Sources: Resident's clinical records, the home's "Food and Fluid Intake Monitoring" policy (CARE7-0.10.02, last revised March 2021), interviews with RPN, RN, RD and ADOC.

[741673]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that symptoms indicating the presence of infection for a resident were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections (HAIs).

Rationale and Summary

A resident exhibited specific symptoms, and later tested positive for an infection. The resident's progress notes indicated that staff failed to monitor and record signs and symptoms of infection when they were symptomatic of the infection.

The home policy titled "Infection Surveillance Protocols" last revised in March 2023 directed unit nurse/designate to document signs and symptoms of the resident infection in the electronic health record each shift until resolved.

The Infection Prevention and Control (IPAC) Lead verified that when a resident had symptoms of an infection, staff were to monitor the resident, and document the symptoms in a progress note on every shift. The IPAC Lead reviewed the resident's progress notes and acknowledged staff had not monitored and documented on each shift when the resident had infection.

Failure to monitor the resident's infection placed them at risk for inadequate treatment and delayed recovery.

Sources: Resident's progress notes, home's policy "Infection Surveillance Protocols" IPC6-O10.o1 last revised March 2023, and interview with IPAC Lead.

[741673]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

(1) Ensure all direct care staff (Personal Support Workers (PSW), RPNs, RNs) are re-educated on hand hygiene practices in accordance with the home's hand hygiene program.

(2) Audit hand hygiene practices on all floors for a period of four weeks on day and evening shifts, following the service of this order, to ensure staff support residents with hand hygiene using 70-90% Alcohol-Based Hand Rub (ABHR).

(3) Maintain a record of the education provided, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training.

(4) Maintain a record of the audits, including the date, result of each audit, the staff member who conducted the audit, and the actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented.

Specifically, Section 10.1, "the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% ABHR.

Rationale and Summary

During a dining service on a home area, staff were observed using wet wipes to

perform residents' hand hygiene prior to serving meals. Later that day at lunch meal service, same wet wipes were also observed being used by staff during meal service and in the activation room on a different home area for residents' hand hygiene following meals.

Upon review the label of the wet wipes, it was discovered that they were personal care wipes and were not alcohol-based.

The home's policy titled "Resident Hand Hygiene" last revised in March 2023 indicated sanitizing wet wipes with at least 70% alcohol may be used by/for resident hand hygiene.

A PSW and RN both acknowledged that wet wipes were used to clean residents' hands before meals, however they both were unsure if wet wipes contained any alcohol content. The IPAC lead acknowledged that the personal care wipes that were used to clean residents' hands prior to their meals did not contain any alcohol and should not have been used for hand hygiene.

Due to the home not ensuring access to 70-90% ABHR, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: Dining observation, IPAC Standard for LTCH's last revised April 2022, home's Resident's hand hygiene policy #IPC2-O10.14-ON-LTC, last revised March 2023, interviews with PSW, RN and IPAC lead.

(741673)

This order must be complied with by May 8, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.