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

Public Report

Report Issue Date: March 27, 2025

Inspection Number: 2025-1228-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Harold and Grace Baker Centre

Long Term Care Home and City: Harold and Grace Baker Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-7, 10-14, 17-21, 26-27, 2025

The following intake(s) were inspected:
Intake: #00140886 - related to a disease outbreak
Intake: #00137996 - related to neglect of a resident
Intake: #00138134 - related to staff to resident physical abuse
Intake: #00140838 - related to an injury of unknown cause

The following intakes were inspected in this Complaint inspection:
Intake: #00133173 - related to neglect, improper care, nutrition and hydration, pain management, staffing, housekeeping, and dealing with complaints

The following intake was completed in this inspection:
Intake: #00133795 - related to a disease outbreak

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

Resident Care and Support Services

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary

The licensee has failed to ensure that a resident's care plan was revised when their care needs changed related to the use of an assistive device.

The resident's care plan was updated to include the use of the assistive device.

Sources: Inspector's observations; review of resident's clinical records; and interview with the Director of Care (DOC).

Date Remedy Implemented: March 12, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the doors leading to a non-residential area was kept closed and locked when they were not being supervised by staff. There were no residents observed in the area. The Nutrition Manager (NM) and Executive Director (ED) both confirmed the door should have been locked.

Sources: Inspector's observations; and interviews with NM and ED.

Date Remedy Implemented: March 6, 2025

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the implementation of the resident's plan of care. The resident's condition changed and a Registered Practical Nurse

(RPN) did not notify the resident's SDM when they transferred the resident to the hospital.

Sources: Resident's clinical records; interview with RPN.

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure a resident was protected from physical abuse by a Personal Support Worker (PSW).

In accordance with the definition identified in Ontario Regulation 246/22 section 2, “physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain.

Sources: Resident's clinical records, home’s investigation notes; interviews with resident, PSW, Registered Nurse (RN), and DOC.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required

under section 53 of this Regulation:
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

The licensee has failed to ensure that a resident's personal device was appropriate for the resident, as it was not based on the resident's current physical condition. The Ministry of Long-Term Care (MLTC) received a complaint that a resident's assistive device was not appropriate for the resident on multiple days.

Sources: Photos of resident's assistive device, resident's clinical records; and interviews with Physiotherapist (PT) and ED.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident as per the resident's care plan.

Sources: Resident's care plan; home's investigation notes; interviews with PSW and DOC.

WRITTEN NOTIFICATION: Housekeeping

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee has failed to ensure the home's procedures for cleaning common areas were implemented for furnishings. There were stains and debris on the furnishings.

Sources: Inspector's observations; interview with Environmental Services Manager (ESM); Chairs, Tables and Lounge Furniture Cleaning Procedure and Dining Rooms (including Celebration Room) Cleaning Procedure.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 a) under the IPAC Standard for

Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that Additional Precautions were initiated when a resident was experiencing symptoms while awaiting results of laboratory testing.

Sources: Resident's clinical records; Infectious Disease Management policy; and interview with IPAC Manager.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when a confirmed disease outbreak was declared by Public Health.

Sources: Critical Incident Report; and interview with the IPAC Manager.

COMPLIANCE ORDER CO #001 Plan of care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

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

1) Provide education to a RN on the home's expectations pertaining to collaborating with staff in the assessment of residents so that their assessments are integrated and are consistent.
2) Maintain a record of the education and training provided including the content, date, signature of attending staff, and the name of person(s) who provided the education.

Grounds

The licensee has failed to ensure that the staff involved in the different aspects of care of residents collaborated with each other in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other.

i) The licensee has failed to ensure that a RN collaborated with the physician in their assessment of a resident when there was a change in health status.

Sources: Resident's clinical records; home's investigation notes; and interviews with RN and ED.

ii) The licensee has failed to ensure that when physiotherapy referrals were sent on two different days for a resident, that a PT collaborated and completed an assessment on the resident within five business days according to the home’s policy “Rehab policy”.

Sources: Resident's clinical records, home's Rehab policy; and interviews with PT and ED.

This order must be complied with by May 9, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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:

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.