

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

<b>Report Issue Date:</b> August 20, 2025
<b>Inspection Number:</b> 2025-1228-0003
<b>Inspection Type:</b> Complaint Critical Incident
<b>Licensee:</b> Harold and Grace Baker Centre
<b>Long Term Care Home and City:</b> Harold and Grace Baker Centre, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7, 11-14, and 18-20, 2025

The following intake(s) were inspected:

- Intake: #00149697/Critical Incident System (CIS) #2732-000020-25 was related to staff to resident abuse.
- Intake: #00152889/CIS #2732-000021-25 and Intake: #00153017 were related to residents' breach of privacy and confidentiality.

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

Safe and Secure Home  
Prevention of Abuse and Neglect  
Staffing, Training and Care Standards

## 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 (1) (c)**

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan

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

of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff related to specific intervention during the provision of care.

The resident's care plan indicated a specific intervention for staff to follow. Assistant Director of Care (ADOC) confirmed that the instructions related to the intervention may result in unclear directions for staff members to apply/follow while providing care to the resident.

**Sources:** Resident's clinical records, interviews with Physiotherapist (PT) and ADOC.

### **WRITTEN NOTIFICATION: Plan of care**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care set out in the care plan was provided to a resident as specified in their plan.

The resident's care plan indicated that they required specific staff assistance for Activity of Daily Living (ADL). On an specified date, a Personal Support Worker (PSW) provided assistance to the resident without following specific instructions as per the resident's care plan.

**Sources:** Resident's clinical records, home's investigation notes, interviews with PSW, and ADOC.

### **WRITTEN NOTIFICATION: Pain management**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 57 (2)**

Pain management

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

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

On an specified date, a PSW reported to the Registered Practical Nurse (RPN) that during care, the resident complained of pain. The RPN completed an assessment and administered as needed (PRN) medication to the resident. The resident was reassessed, and continued to report pain, however, a comprehensive pain assessment was not completed nor was the physician called about the resident's unrelieved pain.

**Sources:** Resident's clinical records, interviews with RPN, Registered Nurse (RN) and ADOC.

## COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 18.**

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

**The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 3 (1) 18. [FLTCA, 2021, s. 155 (1) (b)]:**

The plan must include but is not limited to:

The licensee shall prepare, submit and implement a plan to ensure the residents' rights to be afforded privacy in treatment and in caring for their personal needs are respected.

The home may include consultation with the Information and Privacy Commissioner of Ontario, review of all applicable Personal Health Information Protection Act (PHIPA) legislation related to protecting resident's personal health information and the use of social media during on duty or off duty while maintaining privacy of residents.

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

The plan must include the type of retraining involved including who will be responsible for the retraining and when it will be completed.

1. The person(s) responsible for monitoring that PHIPA is being complied, the frequency of monitoring and how it will be documented.
2. The person(s) responsible for taking action if monitoring demonstrates PHIPA is not complied with; and
3. Actions to address sustainability once the home is successful in ensuring compliance with (PHIPA).
4. A plan to address training related to (PHIPA) and any applicable policies and procedures from the home and should include audits on the night shifts to ensure staff are complying with home's policies and procedures.

Please submit the written plan for achieving compliance for inspection #2025-1228-0003, by email to [torontodistrict.mlhc@ontario.ca](mailto:torontodistrict.mlhc@ontario.ca) by September 4, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

### Grounds

The licensee has failed to ensure that residents' rights to be afforded privacy in caring for their personal needs was fully respected and promoted.

A Critical Incident System (CIS) report was submitted to the Director that a PSW posted a video on social media platform of residents during care. The Director of Care (DOC) acknowledged that the PSW breached residents' privacy rights when they posted a video on social media of residents during care.

The residents were unable to comprehend the implications of publicly being exposed on social media, resulting in a violation of their dignity, autonomy and right to privacy without their informed consent. Their inability to consent makes them especially vulnerable to harm, unable to protect their own interests, or recognize that their privacy had been breached.

**Sources:** Residents' clinical records, home's policy "Privacy and Confidentiality" #PRV1-P10 last revised on March 25, 2025, CIS, Video recording, and interviews with DOC.



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

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

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

**This order must be complied with by September 29, 2025**

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

## 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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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

**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

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, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).



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

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

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