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

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Public Report

Report Issue Date: September 23, 2025
Inspection Number: 2025-1228-0004
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): September 17, 18, 19, 22, 23, 2025

The following intake(s) were inspected:

-Intake: #00154900 - [Critical Incident System (CIS)]: 2732-000029-25/2732-000030-25- was related to improper care

-Intake: #00156386 - Complaint - was related to frequent falls

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

Reporting and Complaints
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)
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 the care set out in the plan of care was provided to a resident as specified in the plan.

(i) The resident experienced a fall and their care plan specified two precise interventions as fall prevention measures. However, the Registered Practical Nurse (RPN) stated that the resident was not provided with these specific interventions.

Sources: Resident's care plan and progress notes, and interview with the RPN.

(ii) A resident fell and sustained an injury. The care plan had specified the use of a precise intervention as a fall prevention measure. However, the Personal Support Worker (PSW) stated that they did not apply the specific intervention as specified in the care plan.

Sources: Resident's care plan and progress notes, and interview with the PSW and the Registered Nurse (RN).

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented.

No documentation was found in the resident's Point of Care (POC) by the PSW who was assigned to the resident and the Director of Care (DOC) confirmed the same.

Sources: Resident's POC and interview with the DOC.

WRITTEN NOTIFICATION: Plan of care

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

The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan of care was no longer necessary.

The resident care plan required a specific intervention which was confirmed by the inspector. After a fall with injury, the physiotherapist (PT) recommended removing the intervention as it posed a risk to the resident. The RN acknowledged that registered staff were responsible for updating the care plan and confirmed it was not updated to reflect this change.

Sources: Inspector's observations, resident's care plan and progress notes, and interviews with the PT, and the RN.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk for injury.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's fall prevention and injury reduction policy indicated, the safety of our residents is a top priority. Our primary focus is reducing the incidence, severity and associated outcomes of falls which includes ensuring residents use appropriate interventions. However, this was not followed for a resident.

The resident had a fall with injury and the RN who witnessed the incident stated that a specific intervention identified in the resident's care plan was not in place which contributed to the loss of balance. The Inspector observed that the resident owned several versions of the same intervention, all of which were confirmed as unsafe by the PT. The home was unable to provide evidence that specified intervention had been implemented.

Sources: The Long Term Care Home's (LTCH) policy "Fall Prevention and injury Reduction" (CARE5-P10, last reviewed March 31, 2024), resident's clinical records, and interview with the RN, the PT and the DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint related to a resident including the date of the action, time frames for actions to be taken and any follow-up action required.

The LTCH was unable to provide documentation of actions taken, including the date of the action, time frames for actions to be taken and any follow-up actions required related to the complaint received concerning the care of a resident. The Executive Director (ED) acknowledged there was no documented record, stating that although they reviewed the video and progress notes, they did not document these actions.

Sources: LTCH's Complaint Log and interview with the ED.