Ontario

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
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Public Report

Report Issue Date: December 19, 2025
Inspection Number: 2025-1228-0007
Inspection Type: 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): December 15-16, 19, 2025
The inspection occurred offsite on the following date(s): December 18, 2025

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00163716 [CI #2732-000040-25] - related to a disease outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 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).

All staff, students, volunteers and support workers were required to comply with

applicable masking requirements at all times.

A unit was in a respiratory outbreak. Signs posted by the entrance into the unit indicated a mask was to be worn.

A Personal Support Worker (PSW) wore their mask below their nose when entering a resident room, and when beside the resident who was in bed. The PSW acknowledged the unit was in a respiratory outbreak and that the mask should be worn covering their nose to protect themself and the resident.

The IPAC Manager indicated wearing the mask below the nose posed a risk for disease transmission.

Sources: Observation, interviews with a PSW and IPAC Manager.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

A unit was in a respiratory outbreak.

A Laundry Aide (LA) exited a resident's room and then immediately entered another resident's room without performing hand hygiene (HH). The LA indicated they did not perform HH because they did not touch anything.

The IPAC Manager indicated HH was required to be performed when entering and exiting resident rooms to prevent transmission of the virus.

Sources: Observation, interviews with a LA and IPAC Manager.

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) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

A resident was on isolation for a respiratory infection.

A Registered Practical Nurse (RPN) indicated residents on isolation were monitored every shift by multiple staff.

The IPAC Manager confirmed there was no documentation of symptom monitoring for the resident on one shift during their isolation period.

Sources: Resident's clinical records, interviews with an RPN and IPAC Manager.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #004 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.

Toronto Public Health confirmed a respiratory outbreak in the home on a specific date. The IPAC Manager acknowledged a Critical Incident (CI) report was submitted late to