Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 4, 2019	2019_642698_0008	016219-18, 033760-18	Complaint

Licensee/Titulaire de permis

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

Long-Term Care Home/Foyer de soins de longue durée

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 4-7, 11-14, 17-21, 2019.

**Intake log #016219-18 and 028144-18 related to abuse; and
Intake #033760-18 related to multiple resident care areas.**

Critical Incident Systems (CIS) Intake log #028144-18 from a concurrent inspection 2019_642698_0009 was inspected in this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and resident's family members.

During the course of the inspection, the inspector conducted interviews, review of clinical health records, and relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.
For the purposes of subsection 2 (1) of the Act, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self worth, that is made by anyone other than a resident.

A Complaint log # 016219-18 along with Critical Incident Systems (CIS) #2732-000024-18, log # 028144-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging staff abuse towards resident #002.

Inspector interviewed the complainant on a identified date regarding abuse. The complainant expressed concerns regarding alleged staff abuse towards resident #002 over an identified period of time. The complainant stated that resident #002 complained about not being treated nicely by nursing staff in the home. The complainant was encouraged by the home to install a camera in resident #002's room to prove alleged abuse. They indicated that they did not report the abuse immediately and waited a while to compile evidence before approaching the home with their concerns. They eventually reported it but could not give an exact date of when they notified the home.

According to the home's investigation notes, the complainant first contacted the home on specified date regarding their concerns and the home responded on an identified date. The investigation notes also stated that the complainant was encouraged to install a camera in resident #002's room as it was difficult to discipline staff without proof. Subsequent emails followed between the complainant and the home. Review of the investigation notes on a specified date, regarding a meeting with the complainant and family held on an identified date, stipulated that video footage provided with incidents that occurred in an identified month over an identified period of time would be reviewed. Video footage provided by the complainant was reviewed by inspector. Incidents in the identified month showed PSW #110 and RPN #111 verbally abusing resident #002.

The investigation notes showed that PSW #110 was terminated by the home and RPN #111 resigned on identified dates.

Interview with ED #102 on a specified date stated that at the time these concerns were brought to the home, the complainant was reviewing the videos when they came across the incidents. ED #102 went on to say that the videos recorded in an identified month were shared with the home on an identified month and that staff could not recall the incidents as significant time had passed. The investigation notes showed that the videos

were shared with the home on a specified date. ED #102 also reported that the police was notified.

Review of PSW #110 employee file, showed that they had prior history of resident abuse on record. ED #102 confirmed the outcome of their investigation resulted in the termination of PSW #110 and RPN #111 due to abuse of resident #002. [s. 19. (1)]

Issued on this 5th day of July, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.