Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 12, 2020	2020_767643_0021	002446-20, 002447-20, 002448-20, 010799-20, 011119-20, 016772-20	Critical Incident System

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

ADAM DICKEY (643), NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 19 - 23, and 26 - 28, 2020.

The following Critical Incident System (CID) intakes were inspected during this inspection:
Log #010799-20, CIS #2732-000007-20 - related to prevention of abuse,
Log #011119-20, CIS #2732-000008-20 and Log #016772-20, CIS #2732-00009-20 - related to falls prevention and management.

The following Compliance Order (CO) follow-up intakes were inspected during this inspection:
Log #002446-20 - related to residents' rights,
Log #002447-20 - related to plan of care, and
Log #002448-20 - related to safe transferring and positioning techniques.

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

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, the home's incident investigation notes, auditing documentation of transferring and positioning techniques, staff education records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2019_817652_0029	643
O.Reg 79/10 s. 36.	CO #003	2019_817652_0029	643

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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to one resident as specified in the plan related to transfer equipment.

Review of a CIS report and progress notes showed the resident had previous falls with injury requiring transfer to hospital. Observation by the inspector showed the resident was assisted with transferring using a lifting device by two staff members. A transfer logo was observed and the resident's plan of care was reviewed, which showed a different transfer method and equipment was to be used. PSW #101 was interviewed, and stated that although they were aware of the correct method, they assisted the resident using the second type of equipment based on their personal judgement. The PSW indicated the resident was easier to transfer using the second type of transfer equipment. The resident #007 was at risk of injury as they were not assessed to safely transfer with the equipment staff were observed to utilize.

Sources: CIS report, resident observations, progress notes, safe ambulation lift and transfer (SALT) assessments, fall risk assessment, care plan, transfer logo, and interviews with PSW and other staff members. [s. 6. (7)]

2. The licensee has failed to ensure that safety equipment was in place for two residents as specified in the residents' plan of care.

a. Observations by the inspector showed resident #007 with safety equipment improperly applied. The following day the resident was observed without the safety equipment applied. The resident’s care plan indicated they were at risk for falls and had interventions in place including the above mentioned safety equipment to be applied daily. The assigned PSW #101 stated that resident's fall interventions in place included the safety equipment, but they only found part of the equipment to apply. Interviews with staff members indicated that the equipment should be in place as a fall prevention and management intervention. Resident #007 was at risk of injury due to having fall risk, and safety equipment was not in place as per the plan of care.

Sources: resident observations, progress notes, fall risk assessments, care plan, and interviews with PSW #101 and other staff members.

b. Due to identified non-compliance with LTCHA 2007, c. 8, s. 6. (7) for resident #007, the scope of residents reviewed was expanded to include resident #005. Observations by Inspector #764 on two consecutive dates showed resident #005 without safety equipment applied. The resident’s care plan indicated that the resident was at risk for falls, and was to use the above safety equipment daily. In an interview, a PSW stated that the equipment was not found in the resident's room and was not in place on either

day as observed by the inspector. Registered staff stated the safety equipment was a part of a fall prevention strategy and should be in place for the resident. Resident #005 was at risk for injury from falls and did not have safety equipment in place as specified in the resident's plan of care.

Sources: resident observations, care plan and interviews with registered and PSW staff members. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents.

An allegation that a resident was hit by a night nurse, was received by a member of the registered staff, during morning medication pass. The resident was visited later in the day by family members, at which time the family communicated to the registered staff member that the resident was stating they were hit. The registered staff member indicated that they then left messages for the DOC and spoke with the ED who spoke to the family and initiated the investigation. Review of the home's policy showed that all persons have a duty to report any form of alleged abuse immediately to the ED. The allegation was not immediately reported to the ED as per the home's policy.

Sources: CIS report, the home's investigation notes, resident #009's progress notes, interviews registered staff members and the home's policy titled "Resident Non-Abuse Program", policy #ADMIN-P10-ENT, last reviewed March 31, 2019. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ADAM DICKEY (643), NAZILA AFGHANI (764)
Inspection No. / No de l’inspection :	2020_767643_0021
Log No. / No de registre :	002446-20, 002447-20, 002448-20, 010799-20, 011119-20, 016772-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 12, 2020
Licensee / Titulaire de permis :	Harold and Grace Baker Centre 1 Northwestern Avenue, TORONTO, ON, M6M-2J7
LTC Home / Foyer de SLD :	Harold and Grace Baker Centre 1 Northwestern Avenue, TORONTO, ON, M6M-2J7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Christine Langton

To Harold and Grace Baker Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_817652_0029, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (7).

Specifically the licensee must:
1. Review residents' plan of care and ensure that safety equipment is provided to residents who require it for injury prevention.
2. Conduct random audits, for one month from the date of this order, of residents requiring safety equipment to ensure the equipment is in place as per the resident's plan of care.
3. Maintain a record of audits conducted including date of audit, resident name, direct care staff name, result of audit and any corrective action taken as a result of the audit.
4. Discuss with PSW #101 the importance of using the correct transfer equipment for resident #007, and the risk involved to the resident during transferring. Document this discussion including date, and staff acknowledgement of the discussion.

Grounds / Motifs :

1. Compliance order #002 related to LTCHA 2007, c. 8, s. 6. (7) from inspection #2019_817652_0029 issued on February 3, 2020, with a compliance due date of September 24, 2020 is being re-issued as follows:

The licensee has failed to ensure that the care set out in the plan of care was provided to one resident as specified in the plan related to transfer equipment.

Review of a CIS report and progress notes showed the resident had previous

falls with injury requiring transfer to hospital. Observation by the inspector showed the resident was assisted with transferring using a lifting device by two staff members. A transfer logo was observed and the resident's plan of care was reviewed, which showed a different transfer method and equipment was to be used. PSW #101 was interviewed, and stated that although they were aware of the correct method, they assisted the resident using the second type of equipment based on their personal judgement. The PSW indicated the resident was easier to transfer using the second type of transfer equipment. The resident #007 was at risk of injury as they were not assessed to safely transfer with the equipment staff were observed to utilize.

Sources: CIS report, resident observations, progress notes, safe ambulation lift and transfer (SALT) assessments, fall risk assessment, care plan, transfer logo, and interviews with PSW and other staff members. [s. 6. (7)]

2. The licensee has failed to ensure that safety equipment was in place for two residents as specified in the residents' plan of care.

a. Observations by the inspector showed resident #007 with safety equipment improperly applied. The following day the resident was observed without the safety equipment applied. The resident's care plan indicated they were at risk for falls and had interventions in place including the above mentioned safety equipment to be applied daily. The assigned PSW #101 stated that resident's fall interventions in place included the safety equipment, but they only found part of the equipment to apply. Interviews with staff members indicated that the equipment should be in place as a fall prevention and management intervention. Resident #007 was at risk of injury due to having fall risk, and safety equipment was not in place as per the plan of care.

Sources: resident observations, progress notes, fall risk assessments, care plan, and interviews with PSW #101 and other staff members.

b. Due to identified non-compliance with LTCHA 2007, c. 8, s. 6. (7) for resident #007, the scope of residents reviewed was expanded to include resident #005. Observations by Inspector #764 on two consecutive dates showed resident #005 without safety equipment applied. The resident's care plan indicated that the resident was at risk for falls, and was to use the above safety equipment

daily. In an interview, a PSW stated that the equipment was not found in the resident's room and was not in place on either day as observed by the inspector. Registered staff stated the safety equipment was a part of a fall prevention strategy and should be in place for the resident. Resident #005 was at risk for injury from falls and did not have safety equipment in place as specified in the resident's plan of care.

Sources: resident observations, care plan and interviews with registered and PSW staff members.

An order was made by taking the following factors into account:

Severity: Safety equipment was not in place for residents #005 and #007 as specified in the residents' plan of care. Minimal risk of harm was identified as both residents were at risk of falling and did not have protective equipment in place. Resident #007 was transferred using equipment not specified in the resident's plan of care. Resident #007 was at minimal risk of harm as the resident was cognitively and physically impaired and was at risk for falls.

Scope: The scope of this noncompliance was a pattern as the care set out in the plan of care was not provided to two of the three residents reviewed as specified in the plan.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 6. (7) of LTCHA 2007. This subsection was issued as a CO on February 3, 2020, during inspection #2019_817652_0029 with a compliance due date of September 24, 2020. The home was issued two other COs in the past 36 months.
(764)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office