Ontario

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

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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_0022	001229-20, 002410-20, 006556-20, 006625-20	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

ADAM DICKEY (643), NAZILA AFGHANI (764)

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): October 19 - 23, and 26 - 28, 2020.

The following complaint intakes were inspected during this inspection:
Log #006556-20 - related to alleged neglect; and
Log #001229-20 - related to medication management.

The following Critical Incident System (CIS) intakes were inspected during this complaint inspection:
Log #006625-20, CIS #2732-000006-20; and Log #002410-20, CIS #2732-000002-20 - related to alleged neglect.

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), Registered Dietitian (RD), Personal Support Workers (PSW), residents, and family members.

During the course of the inspection, the inspector(s) conducted observations of resident and staff interactions and the provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect neglect of a resident immediately reported the suspicion and the information it was based on to the Director.

Review of a CIS report submitted to the Ministry of Long-Term Care (MLTC) indicated an incident of alleged neglect of a resident. The allegation was first reported to the Director six days after the alleged neglect took place. Review of the home's investigation reports showed that a complaint email from the resident's family member was received and acknowledged by the ED two days after the alleged neglect. The email complaint alleged that care was not provided to the resident for approximately 12 hours. The home's investigation showed neglect in care was suspected three days before the suspicion was reported to the Director. During interviews with the DOC and ED, they stated that any alleged, suspected or witnessed neglect of a resident should be reported immediately to the Ministry of Long-Term Care (MLTC). During interview with ED, they confirmed that the suspected neglect was not reported immediately to the Director.

Sources: CIS report, the home's policy titled "Mandatory Reporting of Resident Abuse or Neglect", policy #ADMIN-O 10.01, reviewed March 31, 2017, email communication between the resident's family member and the home, the home's investigation reports and interviews with the DOC and the ED. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that the supplies to meet the nursing needs of one resident were readily available at the home.

The MLTC received a complaint which indicated a resident was sent to hospital and had been noted to be dehydrated. The resident had a physician's order in place for supplemental hydration. The resident had removed the supplemental hydration line, and according to progress notes, the hydration was stopped. A registered staff member was unable to re-start the hydration for the resident as no supplies for the supplemental hydration were available on the unit. The ADOC indicated they did run low on the supplies due to residents needing additional hydration support during the COVID-19 outbreak in the home. The ADOC indicated there were supplies available in the basement storage of the home, which nurses had access to, but had run out in the unit. The resident was sent to hospital for further assessment where they received treatment before being sent back to the home.

Sources: CIS report, MLTC action line documentation, interview with the resident's family member, resident progress notes, physician's orders, hospital discharge summary, and interviews with the ADOC and other staff. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was unable to toilet independently received assistance from staff to manage and maintain continence.

A complaint was received by the MLTC which indicated that a resident was not assisted with toileting for approximately 12 hours. Review of the resident's care plan showed they were unable to toilet themselves safely and required total assistance from staff to toilet. Review of a complaint received by home indicated that the resident was not toileted as noted above. The home's investigation notes confirmed that the resident was not assisted with toileting for approximately a 12-hour period by two assigned PSW staff. During an interview with a member of the registered staff, they stated that the resident should be toileted every two to three hours. During an interview with an assigned PSW, they stated that the resident had a toileting routine, but they had not toileted the resident after providing morning care. During an interview, the DOC stated that the home's investigation confirmed the resident was not assisted with toileting by the two staff members. The resident was at risk of harm as they were not assisted to toilet as required.

Sources: Interview with the resident's family member, email communication between the family member and the home, the home's investigation notes, the resident's plan of care and interviews with nursing staff and the DOC. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #4: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care related to food and fluid intake was documented for one resident.

The MLTC received a complaint which indicated a resident had been sent to hospital and was noted to be dehydrated. The complaint indicated that when discussing the resident's status with registered staff they were unable to inform the resident's family member how much fluid the resident was consuming. Documentation of the resident's food and fluid intakes were incomplete on eight of 13 days in April, 2020. Interviews with staff indicated that PSW staff were expected to document on resident food and fluid intakes in point of care (POC), and report to registered staff if residents were not eating and drinking well. The DOC indicated that staff were not given direction to limit documentation of food and fluid intakes during the COVID-19 outbreak in the home. The resident was sent to hospital for further assessment where they received treatment before being sent back to the home.

Sources: Interview with resident family member, review of resident POC documentation, progress notes, interviews with the DOC, and other staff members. [s. 6. (9) 1.]

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.