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

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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
Apr 27, 2022	2022_846665_0006	002653-21, 002727-21	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

JOY IERACI (665)

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): March 25, 28 and 29, 2022; Off Site March 30 and 31, 2022.

The following intakes were inspected in this Complaint inspection:
Log #002653-21 related to nutrition and hydration and;
Log #002727-21 related to skin and wound.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Skin and Wound Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and family members.

During the course of the inspection, the inspector reviewed clinical records and relevant home policies.

Inspector #589 was present during this inspection.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident's needs related to skin and wound.

The Ministry of Long Term Care (MLTC) received a complaint regarding the home's management of a resident's altered skin integrity.

The resident had an area of altered skin integrity. The area had a change in status seven days later. The weekly skin and wound assessment on day 11 indicated the altered skin integrity had deteriorated. One week later, the area further deteriorated and increased in size requiring intervention by the physician.

The Skin and Wound Nurse indicated they conducted weekly skin and wound assessments. Any recommended treatments were to be included in the physician orders and the resident's electronic treatment administration record (ETAR). On day 11 and 16 after the altered skin integrity’s discovery, the Skin and Wound Nurse assessed the area to require a specified treatment. They confirmed that the treatment was not included in the resident’s physician orders and ETAR, until it had deteriorated requiring intervention by the physician. The Skin and Wound Nurse stated that the resident did not receive the treatment as per their assessment since the treatment was not included in the physician orders and ETAR.

DOC acknowledged that based on the Skin and Wound Nurse’s assessment, the specified treatment should have been included in the resident's plan of care.

There was actual harm to the resident when treatments for their altered skin integrity were not included in their plan of care. The altered skin integrity had deteriorated, increased in size and required intervention by the physician.

Sources: Record review of resident's Skin and Wound Assessments, ETARs, physician orders and interviews with Skin and Wound Nurse and DOC.
[s. 6. (2)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

A resident had two areas of altered skin integrity. The weekly skin and wound assessments were not consistently completed for both areas of altered skin integrity as follows:
A) Area One - only one assessment was completed upon its discovery. Two weekly assessments were not completed after being discovered.
B) Area Two - three assessments were not completed over a two month period.

The DOC acknowledged that the weekly skin and wound assessments were not completed consistently for the resident.

There was minimal risk of harm to the resident when the weekly skin and wound assessments were not completed. There was no documentation on the status of Area One after its discovery, and the last assessment for Area Two indicated the altered skin integrity was improving.

Sources: Review of resident's Skin and Wound Assessments and progress notes and interviews with DOC and other staff. [s. 50. (2) (b) (iv)]

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

The home received a written concern regarding the home's management of a resident's altered skin integrity.

DOC stated they did not submit the written concern to the Director.

Sources: Review of written concern and interview with DOC. [s. 22. (1)]

Issued on this 27th day of April, 2022

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

Original report signed by the inspector.