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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 18, 2024	
Inspection Number: 2024-1228-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Harold and Grace Baker Centre	
Long Term Care Home and City: Harold and Grace Baker Centre, Toronto	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s) Goldie Acai (741521)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27-30, 2024 and June 3-7, 2024

The following intake(s) were inspected:

- Intake: #00117184 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 351 (2) 1.
Protection of privacy in reports
s. 351 (2) Where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only the following shall be posted, given or published, as the case may be:

1. Where there is a finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding.

The licensee has failed to ensure that where an inspection report mentioned in O. Reg. 246/22, section 351 clause (1) (a), (c) or (d) contained personal information or private health information, only a public version of the report, that had been edited by an inspector, was posted.

Rationale and Summary
On two wings of the home, a copy of the Original Licensee Report not edited by an inspector was posted in a public area. The Director of Care (DOC) confirmed the reports posted contained private health information of residents, thus there was a risk for a breach of privacy of resident information.

The home replaced the postings of the Original Licensee Report with the Original Public Report.

Failure to publish a version of the report that has been edited by an inspector increased the risk of privacy breaches of resident information.

Sources: Observations of the original Licensee Report posted on two wings of the home; and an interview with the DOC.
[741521]

Date Remedy Implemented: May 27, 2024

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WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed.

Rationale and Summary
During an observation, a specific device was used by two staff members to transfer the resident to the shower chair. Record review of the resident's care plan for bathing reflected to use a different specific device for transfers with two staff assistance. Further review of the resident's clinical records indicated that the resident was assessed by the Physiotherapist and recommended to use the first specific device for transfers.

The Registered Practical Nurse (RPN) stated that the resident prefers showers and staff used specific device for all transfers. The Assistant Director of Care (ADOC) acknowledged that the resident required two-person assistance for transfers using the specific device recommended by the Physiotherapist and that their care plan was not updated after they were assessed by Physiotherapist.

Failure to update the plan of care in relation to the resident's transfers placed the resident at risk for injury.

Sources: Review of resident's clinical records; and interviews with RPN, and ADOC. [741673]

WRITTEN NOTIFICATION: Doors in a Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access.

Rationale and Summary
(i) A storage room door was observed to have been unlocked. The storage room contained briefs and other supplies that were used for resident care, and a large bucket that contained flammable materials. The RPN acknowledged that the door leading to the non-residential area should have been kept locked when not being supervised by staff.

(ii) A linen room, as well as the staff women's washroom where both locks malfunctioned, leaving these doors unlocked and accessible to residents. The RPN stated a service order was sent to maintenance to repair both locks after they became aware of this situation this afternoon.

Failure to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access increased the risk of resident injury.

Sources: Observations of the storage area, linen rom, and women's staff washroom within the home; and an interview with the RPN.
[741521]

WRITTEN NOTIFICATION: Windows

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (cm).

The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 cm.

Rationale and Summary
An observation was conducted with the Environmental Service Manager (ESM) and it was noted that windows opening in two resident’s rooms measured approximately 28 cm.

During an interview, the ESM stated that the window in one of the rooms was being fixed by the maintenance staff due to damage caused by an incident from the previous night. The window in the second resident’s room was recently cleaned, however the maintenance staff forgot to install the stopper that locks the window in

place. The ESM acknowledged that both windows should not open greater than 15 cm and that there was risk to residents when the windows opening exceeded 15 cm.

Failure to ensure windows leading to the outdoors that were accessible to residents could not be opened more than 15 cm, increased the risk of resident elopement and injury.

Sources: Observation of residents' rooms; and interview with the ESM.
[741673]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

The licensee has failed to ensure that two residents plan of care was based on an interdisciplinary assessment of seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

Rationale and Summary
A record review of two residents plan of care indicated that the residents heat risk assessments were not completed for the year 2024 and their plans of care were not based on the seasonal heat related illness.

The home's policy titled "Heat Related Illness" stated all residents were to be assessed via the Heat Risk Assessment between March 1 and April 30th annually, to determine seasonal risk for heat related illness. The plan of care was to be developed based on risk level.

The RPN and ADOC, both acknowledged that heat assessments were not completed for two residents. The ADOC acknowledged that the heat risk assessment should have been completed for all residents annually and their plan of care should be based on that assessment.

Failure to ensure the plan of care included an assessment of the residents' risk for heat-related illnesses placed residents at risk for potential heat related illness.

Sources: Review of two residents clinical records, and the home's policy titled "Heat Related Illness" #CARE10-O10.09 last revised in March 31, 2024; and interviews with RPN and ADOC.
[741673]

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that food and fluids were served at a temperature

that was both safe and palatable to residents.

Rationale and Summary
During lunch service, the Dietary Aide was observed plating foods for residents. The inspector asked the dietary aide to provide food temperatures recording sheet and it was noted that none of the food temperatures were recorded for lunch. The Dietary Aide later confirmed that they were aware of the process of taking food temperatures but had forgotten to record it for the lunch meal service.

The home's policy titled "Food Temperature Checklist" directed Cook/Food Service Worker to record the temperatures of the menu items for all diet types and textures at the point of service or steam table and immediately after taking temperature, records on the 'Meal Service Daily Temperature Record/in Menu Software System.'

The Director of Dietary Services (DDS) and Dietary Manager (DM), both indicated that during meal services, dietary aides were responsible to take and record food temperatures at the beginning of the meal service and acknowledged that none of the food temperatures for the lunch meal service was taken nor recorded prior to serving that meal.

Failure to ensure food temperatures were recorded and documented by the dietary staff just before serving meals increased the risk of food not being served at a temperature that was both safe and palatable to residents.

Sources: Observation of the lunch meal service; a record review of the home's policy titled "Food Temperature Checklist" #17-020.02 last revised in April 30, 2023, food temperature logs; and interviews with Dietary Aide, DDS and DM.
(741673)

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 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).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes', last revised September 2023, section 9.1, the licensee shall ensure that routine practices and additional precautions were followed in the IPAC program. At minimum routine practices shall include, proper use of PPE, including appropriate selection.

Rationale and Summary
A Dietary Aide was observed on an outbreak unit, within the dining area serving breakfast to residents without wearing a face shield.

The IPAC Lead acknowledged that all staff working on an outbreak unit must wear face shields when on the unit as per the Ministry of Health guidelines.

Staff failure to wear a face shield increases the risk for infection transmission during an outbreak.

Sources: Observation of Dietary Aide; and interview with the IPAC Lead.
[741521]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #008 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.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of incidents in the home, followed by the report required for an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
(i) On February 5, 2024, an Influenza A outbreak was declared by Toronto Public Health. The DOC confirmed the Director should have been informed the same day, however, the home submitted the Critical Incident (CI) one day later.

(ii) On March 30, 2024, an enteric outbreak was declared by Toronto Public Health.

The home failed to immediately inform the Director of the outbreak; a CI was not submitted until on April 1, 2024. The DOC stated that this report should have been made on the same day the outbreak was declared using the afterhours action line.

Failure to immediately inform the Director on an outbreak, could delay follow up, and minimize the potential responses required to manage significant concerns.

Sources: Record review of Long-Term Care Homes.net CI's, and emails from Toronto Public Health; and interview with the DOC.
[741521]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the continuous quality improvement committee for a home included a regular nursing staff employed at the home.

Rationale and Summary
The DOC confirmed that the long-term care home (LTCH) had an established continuous quality improvement (CQI) committee who met every three months. The DOC stated the home's CQI committee did not include a member of the regular

nursing staff employed at the home.

Failure to include at least one employee of the licensee who was a member of the regular nursing staff, impacts engagement of frontline staff in their effort to improve care and services.

Sources: A record review of the quarterly CQI Reports; and interview with the DOC. [741521]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement committee for a home included a Personal Support Worker (PSW) employed by the home.

Rationale and Summary
The DOC confirmed that the LTCH had an established continuous CQI committee who met every three months. The DOC confirmed that the home's CQI committee did not include a PSW employed by the home.

Failure to include one PSW who was employed by the home, impacts engagement of frontline staff in their effort to improve care and services.

Sources: A record review of the quarterly CQI Reports; and interview with the DOC. [741521]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the continuous quality improvement committee for a home included at least one member of the home's Residents' Council.

Rationale and Summary
The DOC confirmed that the LTCH had an established CQI committee who met every three months. According to the DOC, at least one member of the Residents' Council was not included as a member on CQI Committee for the meeting.
Failure to include at least one member of the home's Residents' Council, impacts engagement of stakeholders in the effort to improve care and services.

Sources: A record review of the quarterly CQI Report; and an interview with the

DOC.
[741521]

WRITTEN NOTIFICATION: CMOH and MOH

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Specifically, the 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings,' dated April 2024, section 3.1 states alcohol-based hand rubs (ABHR) must not be expired.

Rationale and Summary
During an observation, two 700 milliliters (mL) units of ABHR located in one of the Janitors' room, and an additional six units of the same products were found in the basement storage room, with an expiry date of March 2024. The ESM confirmed that all ABHR units within the dispensing units of resident rooms of the home were expired.

The DOC and IPAC Lead, both confirmed that expired ABHR products should not

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have been used by staff, and stated expired ABHR products may not have full potency to eliminate bacteria due to the potential evaporation of the alcohol content. Both DOC and IPAC Lead confirmed the use of expired ABHR products increased the risk for disease transmission.

Failure to ensure that the ABHR in residents' rooms were not expired, increases the potential risk for spread of infection in the home.

Sources: Observations; record review of 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings,' dated April 2024, and interviews with DOC, ESM, and IPAC Lead.
[741521]