Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: July 18, 2024
Inspection Number: 2024-1228-0003
Inspection Type: Critical Incident Follow up
Licensee: Harold and Grace Baker Centre
Long Term Care Home and City: Harold and Grace Baker Centre, Toronto

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 25, 27-28, July 2-5, 8-10, 2024.

The following intake(s) were inspected:
• Intake: #00113017 - Follow-up related to infection prevention and control
• Intake: #00118016 [Critical Incident (CI)- 2732-000012-24] was related to improper care
• Intake: #00118967 [CI-2732-000015-24] was related to abuse

The following intake(s) were completed:
• Intake: #00112683 - [CI: 2732-000007-24]; Intake: #00112720 [CI: 2732-000008-24]; Intake: #00117433 [CI: 2732-000010-24] were related to infection prevention and control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1228-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Cindy Ma (000711)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in their plan.

Rationale and Summary
A resident's plan of care indicated that staff were required to use a certain size of equipment for safe transfers of the resident.

The Inspector observed two Personal Support Workers (PSWs) used an incorrect size of equipment during a transfer of the resident.

A PSW acknowledged that they should have utilized the appropriate size of equipment to ensure a safe transfer of the resident.

A Nurse Manager and the Director of Care (DOC) both acknowledged that staff failed to follow the resident's plan of care when they did not utilize the appropriate size of equipment when transferring the resident.

Failing to follow the plan of care related to the use of appropriate transferring equipment put the resident at risk for potential harm.

Sources: Inspector's observation; resident's clinical records; and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that safe transferring techniques were used for a resident.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director related to an injury sustained during an improper transfer of a resident.

The resident required specific assistance for safe transferring.

Record reviews and staff interviews indicated that during a shift, unsafe transfer was performed for the resident. While the resident was being transferred, both PSWs noticed that a part of the transfer equipment was not properly secured. The resident slid out and fell to the floor sustaining an injury.

The two PSWs acknowledged that they performed an unsafe resident transfer.

There was risk of harm to the resident when staff failed to utilize safe transferring and positioning techniques for the resident, as the resident sustained a fall and injury.

Sources: CIS report #2732-000012-24; resident's clinical records; home's investigation notes; and interviews with staff.