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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 24, 2022
Inspection Number 2022_1309_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Baycrest Hospital

Long-Term Care Home and City
The Jewish Home for the Aged, North York

Lead Inspector
Joy Ieraci (665)

Additional Inspector(s)
Adelfa Robles (723)
Reji Sivamangalam (739633)

Inspector Digital Signature
Maria Joy Ieraci
Digitally signed by Maria Joy Ieraci
Date: 2022.07.11 15:25:12 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25, 26 (off site), 27, 30, 31 and June 1, 2022.

The following intake(s) were inspected:

- Log #017822-21 (Complaint) related to plan of care
- Log #016476-21 (Complaint) related to care and services and skin and wound
- Log #011069-21 (Complaint) related to medication management
- Log #002760-22 (Follow-up) related to infection prevention and control practices

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s.5	2022_846665_0001	001	Joy Ieraci (665)

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

- Infection Prevention and Control (IPAC)
- Medication Management

- Resident Care and Support Services
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 140 (2)

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding a resident's medication was not administered as prescribed. The resident was no longer in the home at the time of the inspection.

Another resident was prescribed the same class of medication. The pharmacy order and medication pouch indicated, "Hazardous-handle properly, do not crush".

A Registered Practical Nurse (RPN) crushed the resident's medications.

The RPN indicated, that if a resident was on crushed medications, all medications were crushed including the above-mentioned type of medication. Two LTC Managers and the home's pharmacy consultant confirmed that the medication was not administered as prescribed as it was not to be crushed.

Failure of the home to administer the class of medication as prescribed can alter the effectiveness of the drug and increase the risk of exposure to health care workers.

Sources: Review of a resident's clinical records, medication pass observation, interviews with RPNs, LTC Managers and the Consultant Pharmacist.
[723]

COMPLIANCE ORDER CO#001 INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.102 (8)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

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Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s.102 (8)

The licensee shall:

1) Re-train two registered staff on the use of personal protective equipment (PPE) in accordance with routine practices and additional precautions.

2) Maintain a documented record of the training provided.

Grounds

Non-compliance with: O. Reg. 246/22 s.102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC).

Rationale and Summary
A resident's progress notes indicated that they were on droplet/contact precautions.

IPAC Lead stated the required PPE for droplet/contact precautions were a mask, gloves, eye protection and gown.

A RPN provided direct care to the resident while a registered nurse (RN) was in the resident's room. Both staff were not wearing the required gown.

On two observations, the essential caregiver (ECG) did not wear the appropriate PPE. They only wore a mask on one observation and, eye protection was not worn the following day.

There was a risk of infection transmission to other residents and staff when the registered staff and ECG did not wear the required PPE.

Sources: Record review of a resident's clinical records, resident care observations, interviews with a RPN, IPAC Lead, ECG and other staff.
[665]

This order must be complied with by July 15, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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