Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2021	2021_938758_0004	014838-21	Critical Incident System

Licensee/Titulaire de permis

Unity Health Toronto
3276 St. Clair Avenue East Toronto ON M1L 1W1

Long-Term Care Home/Foyer de soins de longue durée

Providence Healthcare
3276 St. Clair Avenue East Scarborough ON M1L 1W1

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

NOREEN FREDERICK (704758)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 23, 24, 25, and 26, 2021.

The following Critical Incident System (CIS) intake was completed during this CIS inspection:
Log #014838-21 related to improper or incompetent treatment or care of a resident.

Inspector #501 was present as an assessor during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Operational Lead, Infection Prevention and Control (IPAC) manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Resident Assistants (RAs), and a resident.

During the course of the inspection, the inspectors reviewed residents' clinical records, staffing schedules, home's investigation notes, pertinent policies and procedures, and observed IPAC practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring resident #001.

Resident #001 required assistance from two staff members for transferring using a

mechanical lift. Resident Assistant (RA) #100 reported to Registered Nurse (RN) #102 that they observed resident #001 required repositioning. RA #100 stated that they called RA #101 who helped position the resident in the bed.

RA #101 spoke to Operational Lead #104 and disclosed that resident #001 was found on the floor and RA #100 and RA #101 both manually transferred the resident without an assessment by registered staff.

Home's Falls Prevention and Management policy required a registered staff's assessment prior to mobilizing the resident. As a result of physically transferring the resident without the use of any transferring devices, and prior to an assessment by registered staff put resident #001 at further risk for potential injury and harm.

Sources: resident #001’s progress notes, care plan, Falls Prevention and Management policy #HP045 (last revised on July 27, 2021), home’s investigation notes and interviews with resident, RA #100, RA #101, RN #102, Operational Lead #104 and DOC.

2. The licensee has failed to ensure that staff used safe transferring and positioning techniques when positioning resident #003 in bed during their care.

Resident #003's care plan indicated that they required total assistance in bed with two staff to position.

According to Operational Lead #104, RA #100 stated they turned the resident by themselves without another staff’s assistance. As a result, resident #003 sustained an injury.

Director of care (DOC) acknowledged that resident #003 did not receive the required assistance for their safety, which led to their injury.

As a result of positioning the resident without another staff’s assistance, resident #003 experienced actual harm.

Sources: resident #003’s clinical records, home’s investigation notes, interviews with Operational Lead #104 and DOC. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

Resident #002 informed RN #102 and Operational Lead #104 that RA #100 was rude and provided rough care to them which caused pain. DOC stated that rough care was provided to the resident.

By not respecting resident #002's right to be treated with courtesy and respect, staff caused emotional distress to the resident.

Sources: resident 002's progress notes, home's investigation notes, interviews with DOC and other staff. [s. 3. (1) 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 the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors that residents did not have access to were kept closed and locked.

Inspector #704758 observed that a laundry chute door was left propped open by using a yellow wet floor sign on one of the units. The observations were brought to the attention of the DOC, and they stated that the staff were always expected to keep that door closed and locked.

When the laundry chute door was not closed and locked, there was a risk of residents' entering the chute and getting injured.

Sources: inspector's observation, interviews with the DOC and other staff. [s. 9. (1) 1. i.]

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 doors that residents do not have access to must be kept closed and locked is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's infection prevention and control (IPAC) program related to doffing of Personal Protective Equipment (PPE).

Inspector #704758 observed that RA #105 failed to doff PPE when exiting a resident's room who was on isolation precautions. IPAC manager #106 stated that RA #105 was expected to remove PPE and perform hand hygiene when they exited the room.

By not following the home's PPE policy, staff placed residents at risk of getting healthcare associated infections.

Sources: inspector's observation, home's PPE policy (#16-21, last reviewed April 2, 2019), and interview with IPAC manager #106. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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 immediate report to the Director was completed when they had reasonable grounds to suspect improper or incompetent treatment of resident #002.

The home's Mandatory Reporting and Critical Incidents policy required for the Director to be informed immediately if any person had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

On an identified day, resident #002 informed RN #102 and Operational Lead #104 that RA #100 was rude and provided rough care to them which caused pain. The home's Zero Tolerance to Abuse and Neglect policy defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. Operational Lead #104 stated, they failed to report this incident to the Director as they were unaware that the physical abuse definition with respect to a resident who was reporting pain, was grounds to suspect improper or incompetent treatment.

Failing to immediately report the incident of suspected improper or incompetent treatment puts resident at risk for potential continuation of such treatment.

Sources: resident #002's clinical records, home's investigation notes, Mandatory Reporting and Critical Incidents policy # HP107 (last revised on June 11, 2021), and Zero Tolerance to Abuse and Neglect policy #HP020 (last revised on June 11, 2021) and interview with Operational Lead #104. [s. 24. (1)]

Issued on this 30th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	NOREEN FREDERICK (704758)
Inspection No. / No de l’inspection :	2021_938758_0004
Log No. / No de registre :	014838-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 23, 2021
Licensee / Titulaire de permis :	Unity Health Toronto 3276 St. Clair Avenue East, Toronto, ON, M1L-1W1
LTC Home / Foyer de SLD :	Providence Healthcare 3276 St. Clair Avenue East, Scarborough, ON, M1L-1W1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Pat Colucci

To Unity Health Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of the O. Reg.79/10.
Specifically, the licensee must:

1. Conduct random audits of residents who require two-person assistance for transferring and positioning. These audits should be conducted for a minimum of one month, or until no further concerns are identified with staff practice.

2. Maintain a documented record of audits conducted, to include but not be limited to: date of audit, resident name, staff name(s), transfer method and level of assistance required, results of the audit and any corrective action taken in response to the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring resident #001.

Resident #001 required assistance from two staff members for transferring using a mechanical lift. Resident Assistant (RA) #100 reported to Registered Nurse (RN) #102 that they observed resident #001 required repositioning. RA #100 stated that they called RA #101 who helped position the resident in the bed.

RA #101 spoke to Operational Lead #104 and disclosed that resident #001 was found on the floor and RA #100 and RA #101 both manually transferred the resident without an assessment by registered staff.

Home's Falls Prevention and Management policy required a registered staff's assessment prior to mobilizing the resident. As a result of physically transferring

the resident without the use of any transferring devices, and prior to an assessment by registered staff put resident #001 at further risk for potential injury and harm.

Sources: resident #001's progress notes, care plan, Falls Prevention and Management policy #HP045 (last revised on July 27, 2021), home's investigation notes and interviews with resident, RA #100, RA #101, RN #102, Operational Lead #104 and DOC.

2. The licensee has failed to ensure that staff used safe transferring and positioning techniques when positioning resident #003 in bed during their care.

Resident #003's care plan indicated that they required total assistance in bed with two staff to position.

According to Operational Lead #104, RA #100 stated they turned the resident by themselves without another staff's assistance. As a result, resident #003 sustained an injury.

Director of care (DOC) acknowledged that resident #003 did not receive the required assistance for their safety, which led to their injury.

As a result of positioning the resident without another staff's assistance, resident #003 experienced actual harm.

Sources: resident #003's clinical records, home's investigation notes, interviews with Operational Lead #104 and DOC.

An order was issued based on the following factors:

Severity: As a result of these incidents, two residents experienced actual risk of harm.

Scope: This issue was identified as a pattern, as two out of three residents were subject to unsafe transfer by the same RA during this inspection.

Compliance history: The licensee was previously found to be non-compliant with

s. 36 of the O.Reg.79/10 where two Voluntary Plan of Correction (VPC) were issued in the past 36 months.

(704758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 15, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Noreen Frederick

Service Area Office /
Bureau régional de services : Toronto Service Area Office