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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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Original Licensee Report

Report Issue Date: December 16, 2022
Inspection Number: 2022-1503-0002
Inspection Type: Complaint Critical Incident System
Licensee: Unity Health Toronto
Long Term Care Home and City: Providence Healthcare, Scarborough

Lead Inspector	**Inspector Digital Signature**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2022.12.21 14:10:55 -05'00'

Additional Inspector(s)
JulieAnn Hing (649)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5-9, 2022

The following intake(s) were inspected:

- Intake: #00003038-[CI: 3006-000010-22] Improper or incompetent treatment of a resident that resulted in harm or risk of harm to a resident.
- Intake: #00013668 was a complaint related to transfer assessment and pain management.

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

Infection Prevention and Control
Pain Management
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement measures in accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, the licensee failed to ensure that Additional Precautions were followed related to the appropriate application of eye protection as required by Additional Precautions 9.1 (f) under the IPAC Standard.

Rationale and Summary
On an identified date, a staff member was observed entering a resident's room that was identified as a high-risk contact of COVID-19. A droplet/contact precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff. The staff member wore a mask, gloves, and gown prior to entering the room, but did not wear eye protection.

The staff member stated that they are to wear gown, gloves, mask, and face shield when droplet/contact precautions are identified. The IPAC Manager and Director of Resident Care stated that staff should always be following the PPE requirements posted on the door for residents on additional precautions. There was an increased risk of transmission of infection to staff and residents.

Sources: Observations, and interviews with IPAC Manager, Director of Resident Care and other staff.

COMPLIANCE ORDER CO #001 Plan of Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
(1) Prior to the compliance due date, review with all Personal Support Workers (PSWs) and Resident Assistants (RAs) who work in a specified home area, the number of staff required to safely assist each resident on the unit with bathing.
(2) Maintain a record of the review, including the date of the review, list of residents and level of assistance required for bathing, person(s) conducting the review and staff attendance.
(3) Conduct audits of staff adherence to residents' plan of care for bathing in a specified home area, for

a period of three weeks following the service of this order.
(4) Maintain a record of the audits, including the date, who conducted the audit, resident and staff audited, results of each audit and actions taken in response to the audit findings.

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

Rationale and Summary

(i) On a specified date, after a resident's shower, they sustained an injury.

At the time of the incident, the resident required two-person extensive assistance for showers or bathing.

Staff failed to follow the resident's plan of care and provided the resident's shower independently rather than with two staff.

A staff member advised that they had not assisted another staff with the resident's shower during the above incident, as the first identified staff member was not ready for assistance with the resident's transfer. Upon their return to the spa room, they observed that the resident had sustained an injury.

(ii) Following the above-mentioned incident, the resident required two-person total assistance for the entire shower and bathing activity.

A staff member assisted another staff to change the resident's incontinent product but did not assist with the resident's bath.

Staff failure to follow the resident's plan of care with the required number of staff during shower or bathing activity put the resident at risk for injury.

Sources: Observation of the resident's transfer after bath, review of Critical Incident System (CIS) report #3006-000010-22, review of resident's clinical records, and staff interviews.

[649]

This order must be complied with by March 15, 2023

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.