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
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 23, 2023	
Inspection Number: 2023-1503-0003	
Inspection Type: Critical Incident System	
Licensee: Unity Health Toronto	
Long Term Care Home and City: Providence Healthcare, Scarborough	
Lead Inspector Susan Semeredy (501)	**Inspector Digital Signature** Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2023.02.23 13:36:23 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7-10 and 15-17, 2023.

The following intake(s) were inspected:

Intake: #00003358 - Fracture of unknown etiology.
Intake: #00019258 - Alleged neglect/improper care of a resident.
Intake: #00016702 - Falls prevention and management
The following intakes were completed related to falls prevention and management:
Intake: #00005870
Intake: #00013671
Intake: #00018323

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was not neglected by a staff member.

Section 7 of the Ontario Regulation (O. Reg.) 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary
A resident was assisted with an activity of daily living (ADL) by two resident assistants (RAs). The resident was found in the same position several hours later and sustained skin breakdown. The RA assigned to the resident's care admitted they forgot about the resident due to being busy and distracted. A Clinical Operations Lead confirmed this was neglect which put the resident at risk for skin breakdown and injury due to a possible fall.

Sources: The resident's progress notes and interviews with the resident and staff. [501]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure a staff member who had reasonable grounds to suspect neglect of a resident immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The home submitted a Critical Incident (CI) report for an incident that occurred the evening before. An

RA allegedly neglected a resident by leaving them in the same position for several hours. A Registered Nurse (RN) was informed of the incident and wrote a progress note in the resident's record. The RN did not call the after-hours line to the Ministry of Long-Term Care (MLTC) and stated they were from an agency and were not aware of MLTC mandatory reporting protocols. A Clinical Operations Lead acknowledged that the RN should have immediately reported the incident to the MLTC and had been oriented to do so.

Sources: CI report, the resident's clinical record and interviews with staff.
[501]

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the strategy to reduce or mitigate falls when using equipment for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

Specifically, the staff did not comply with the home's internal policy titled "Safe Lifting, Transferring and Transporting" when they used an untrained visitor as a second person when using a mechanical lift. According to the policy, only staff that have received appropriate training are to use resident lift equipment.

Rationale and Summary
A resident was assisted to perform an ADL using a mechanical lift. A transfer was completed with two RAs and a visitor. The transfer back was completed by one RA and a visitor. During this transfer the resident's positioning became abnormal but the transfer was completed. The resident later complained of pain and the next day it was determined that there was an injury.

The Director of Resident Care (DRC) confirmed that visitors were not qualified to participate as the second person in the use of mechanical lifts and in this case, the RA should have sought the assistance of another RA. Failing to follow the home's policy for safe lifting, put the resident at risk for injury.

Sources: The resident's clinical record, home's policy titled Safe Lifting, Transferring and Transporting last reviewed June 2021, and interviews with staff. [501]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Develop an audit tool and schedule for managers/supervisors to complete dining room audits to ensure residents are provided support to complete hand hygiene before meals. Complete daily audits for a period of three weeks. Ensure all dining areas and meals are captured within the schedule.
2. Develop an audit tool and schedule for managers/supervisors to complete for the proper use of personal protective equipment (PPE) for those residents on additional precautions. Complete daily audits for a period of three weeks. Ensure the proper sequence of donning, doffing and hand hygiene is included within the audit.
3. Provide on the spot education and training to staff not adhering with the above infection prevention and control (IPAC) measures.
4. Keep a documented record of the audits and of the training provided to staff regarding the above.

Grounds
A) Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), Infection Prevention and Control (IPAC) Standard Section 9.1 (f)

The licensee has 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 has failed to ensure that Additional Precautions were followed related to the appropriate application, removal and disposal of PPE as required by Additional Precautions 9.1 (f) under the IPAC Standard.

Rationale and Summary
Two rooms beside each other had additional precaution signage on their door. An RA entered the rooms to provide meal trays. The RA when putting on and taking off additional PPE did so in an incorrect sequence and disposed of their PPE improperly.

The DRC confirmed that the proper sequence putting on and taking off PPE was not followed. The DRC also acknowledged that PPE should have been properly disposed of in the garbage for this purpose as soon as it was taken off. The improper application, removal and disposal of PPE increased the risk of

transmission of infection to staff and residents.

Sources: Observations and interviews with the DRC and other staff. [501]

B) Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), Infection Prevention and Control (IPAC) Standard Section 10.4(h)

The licensee has 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 has failed to ensure that support for residents to perform hand hygiene prior to receiving meals was followed as required by 10.4(h) under the IPAC Standard.

Rationale and Summary
In a dining room, residents were not being supported to perform hand hygiene before their meal. An RA stated they had not performed this task and went to look for Alcohol Based Hand Rub (ABHR) and assisted a few residents who had already consumed part of their meal. The DRC acknowledged all residents in the dining room should have been assisted to perform hand hygiene before their meal.

By staff failing to support residents to perform hand hygiene there was an increased the risk of transmission of infection.

Sources: Observation and interviews with the DRC and other staff. [501]

This order must be complied with by April 5, 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.