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: December 7, 2023

Inspection Number: 2023-1503-0007

Inspection Type:
Critical Incident

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: 2023.12.11 14:10:59 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-30, December 1, 4, 5, 2023

The following intake(s) were inspected:

- Intake: #00098636 - [Critical Incident (CI): 3006-000034-23] - Neglect of resident
- Intake: #00099008 - [CI: 3006-000039-23] - Fall with injury
- Intake: #00099016 - [CI: 3006-000041-23] - Infection prevention and control

The following intake(s) were completed in this inspection: Intake: #00095398 - [CI: 3006-000025-23], Intake: #00095868 - [CI: 3006-000027-23], Intake: #00097142 - [CI: 3006-000028-23], and Intake: #00097703 - [CI: 3006-000029-23] were related to fall with injury.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to provide a safe environment for its residents.

Rationale and Summary
On an identified date, resident #001 called for assistance by ringing their call bell. Resident #001 did not receive assistance from staff in a timely manner.

Resident #001's clinical records indicated that a co-resident had a type of interaction with the resident. The Callpoint Detailed Activity Report indicated that the call bell was initiated in resident #001's room for an extended period of time. The home's investigation notes indicated that the call bell went unanswered and that there was lack of communication between staff members.

Resident #001 was upset and stated that they called the call bell multiple times, but staff did not respond. Resident #001 stated they had concerns with their interactions with the co-resident and worried about their safety.

Resident Assistant (RA) #103 stated that they were not aware that the resident required assistance until they returned from their break, and subsequently attended to the resident. Clinical Operations Lead #104 stated that resident #001 did not receive assistance and support from staff and that there was risk to resident #001's safety.

There was an unsafe environment in the home when staff were unavailable to assist resident #001's safety needs in a timely manner.

Sources: Resident #001's clinical records; Callpoint Detailed Activity Report; Home's investigation notes, and interviews with resident #001, RA #103 and Clinical Operations Lead #104.

[740836]

WRITTEN NOTIFICATION: Reporting critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that a disease outbreak was immediately reported to the director.

Rationale and Summary
On an identified date, a disease outbreak was declared in the home. The home reported the incident to the Director on the following day. The IPAC Lead confirmed that the critical incident was not immediately reported to the Director until the following day.

Sources: Critical incident report 3006-000031-23, and interview with IPAC Lead.

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