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: April 3, 2024	
Inspection Number: 2024-1503-0001	
Inspection Type: Critical Incident	
Licensee: Unity Health Toronto	
Long Term Care Home and City: Providence Healthcare, Scarborough	
Lead Inspector Michael Chan (000708)	**Inspector Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2024.04.11 11:04:09 -04'00'
Additional Inspector(s) Jack Shi (760)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-15, 18-21, 25-26, 2024

The following intake(s) were inspected:

- Intake: #00105486 - 3006-000001-24 - Related to a disease outbreak
- Intake: #00108086 - 3006-000003-24 - Related to improper care of a resident
- Intake: #00108252 - 3006-000005-24 - Related to an injury of unknown cause of a resident
- Intake: #00109277 - 3006-000007-24 - Related to improper transfer of a resident resulting in injury
- Intake: #00110473 - 3006-000009-24 - Related to the unexpected death of a resident

- Intake: #00110612 -3006-000010-24 - Related to resident-to-resident physical abuse

The following intake(s) were completed in this inspection:

- Intake: #00107537 -3006-000002-24, Intake: #00108160 -3006-000004-24, Intake: #00108885 - 3006-000006-24 - Related to disease outbreaks

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's written plan of care provided clear

directions in regards to the application of a device for their mobility aid.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Director related to a an injury of an unknown cause that the resident sustained. Resident Assistant (RA) #114 stated that they had observed RA #112 pushing the resident in their mobility aid the day prior to the discovery of the injury. RA #114 had observed RA #112 having difficulty when assisting the resident with locomotion, without a device applied. The resident's plan of care at the time of the incident did not indicate the use of the device was required when staff would assist the resident. The Operations Leader (OL) stated that the injury may have been caused from when RA #112 assisted the resident with locomotion using their mobility aid without the device being applied. The OL stated that the resident's care plan should direct staff on application of the device.

Failure to ensure that the resident's plan of care provided clear directions on the application of the resident's device may lead to the resident further injuring themselves.

Sources: A resident's plan of care; Home's investigation notes; Interviews with an OL and other staff. [760]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the staff performed an intervention on a resident.

Rational and Summary
A staff was present and assisting the resident when the resident had a sudden change in their condition. Staff attended to the resident for further assessment and medical interventions. An intervention was performed by staff on the resident that was not indicated in the resident's plan of care.

Director of Care (DOC) #101 and staff confirmed that the intervention was performed on the resident by staff. DOC #101 confirmed that the intervention provided to resident by staff was not according to the resident's plan of care.

Source: CI 3006-000001-24, Interview with DOC #101 and the home's staff. [000708]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director upon receipt of the complaint.

Rational and Summary
The home received a written complaint via email from a resident's family regarding

the care of the resident. The written complaint was forwarded to the Director seven days later.

DOC #101 acknowledged the written complaint should have been forwarded immediately to the Director.

Failure to immediately forward the written complaint to the Director may have delayed follow up by the Ministry of Long-Term Care.

Source: CIS 3006-000003, Email complaint from the resident's family, Interview with DOC #101. [000708]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to ensure that an alleged incident of improper care to a resident from a Personal Support Worker (PSW) was reported to the Director.

Rationale and Summary:
An incident occurred where the PSW did not follow protocols during providing care to a resident. A CIS report was not submitted to the Director following the discovery of the incident. The DOC stated there was a risk of harm to the resident from the

care being provided by the PSW and therefore, the incident should have been reported to the Director.

Failure to immediately report suspected improper care of the resident placed the resident at risk of continued improper care.

Sources: Review of email communications and progress notes regarding resident #004; CIS report #3006-000007-24; Interview with DOC #101. [760]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking requirements were not followed by a staff.

Rationale and Summary
In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 2, 2023; staff, students, support workers, and volunteers were required to wear a mask when in resident areas indoors.

Review of video surveillance footage of a resident home area, showed a staff was in

a resident area without a mask. DOC #101 indicated that the staff was required to wear a mask at that time.

Failure of the staff to wear a mask in a resident area could lead to risk for infection transmission.

Sources: Video surveillance; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; Interview with DOC #101. [000708]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff utilized safe transferring techniques when assisting a resident.

Rationale and Summary:
A CIS report was submitted by the home related to concerns over a fall that a resident had sustained. The resident required a type of transfer according to their care plan at the time of the incident. A PSW had performed a transfer that did not align with the resident's care plan and as a result, the resident had sustained a fall. A Registered Practical Nurse (RPN) stated that the PSW endangered the resident's health by not ensuring the performed transfer aligned with the resident's care plan.

The DOC confirmed that the PSW did not perform a safe transfer when assisting the resident.

Failure to ensure that the staff used safe transferring techniques when assisting the resident placed them at risk of injury.

Sources: A resident's progress notes, care plan and assessments; Interview with an RPN, the DOC and other staff. [760]

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the fall prevention and management policies and procedures for a resident post-fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the policy "Head Injury Routine", dated June 11, 2021, which was included in the licensee's Falls Program.

Rationale and Summary:
The resident had a fall and was placed on was placed on head injury routine (HIR) monitoring following the fall. A review of the HIR indicated that a Registered Nurse (RN) had documented "asleep" in the HIR monitoring. The RN stated they would rely on the RAs for information on the resident's current condition and review documentation from the previous shift to understand the resident's status. The DOC indicated that it would not be appropriate for the RN to be documenting "asleep" and the RN should not solely rely on other staff members with their assessments on the resident.

Failure to ensure that the HIR was completed while the resident was sleeping may result in staff not being aware if there was a neurological change in the resident's condition.

Sources: Head Injury Routine Policy, dated June 11, 2021; a resident's clinical chart; Interview with the DOC and other staff. [760]

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee has failed to comply with the system that requires daily cleaning and disinfection for high contact surfaces.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there are procedures for cleaning and disinfection in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices related to contact surfaces.

Specifically, staff did not comply with the policy "Infection Control and Safety", dated September 2021, which was included in the licensee's Infection Control Program.

Rationale and Summary
A housekeeper had indicated to the inspector that they would only clean the handrails on their assigned home area on the weekend because of their workload. Another housekeeper similarly stated that according to their job routines, they would clean the handrails once a week and sometimes on weekends as well. The Environmental Services Manager (ESM) stated that handrails on the resident home areas are considered high touch surfaces and should be cleaned daily. The ESM confirmed that these housekeepers failed to meet the cleaning and disinfecting requirements for high-touch surfaces, as indicated in the home's policy.

Failure to ensure that all high-touch surfaces were cleaned and disinfected may result in further spread of infectious diseases.

Sources: Policy titled, Infection Control and Safety, dated September 2021;

Interview with two housekeepers and the ESM. [760]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee failed to ensure that the Infection Prevention and Control (IPAC) lead carried out their responsibilities as it pertained to ensuring a hand hygiene program was followed through in accordance with the standard issued by the Director.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), under section 10.4, section F, residents shall receive support from staff to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary
During two snack time observations, two PSW were observed to provide residents with snacks without offering residents any hand hygiene. On both dates, there were no portable hand hygiene agents on the snack cart. Both PSWs stated they had

never seen any portable hand hygiene agent placed on the snack carts. One PSW could not explain how they provided hand hygiene to residents during snack time while the other PSW was unaware they had to offer hand hygiene to residents prior to snack times.

The IPAC Lead was unaware snack carts were being used in the home and did not supply the carts with portable hand hygiene agents. The IPAC Lead confirmed staff are required to provide hand hygiene to residents before snacks, but this was not previously communicated to front-line staff.

The DOC stated the expectation is portable hand hygiene agents should be available on the snack cart so that staff can provide hand hygiene to residents before serving the snack.

Failure to promote and provide hand hygiene amongst residents prior to them eating or drinking may result in further spread of infectious diseases.

Sources: Observations in two resident units; Interview with two PSWs, the IPAC Lead and the DOC. [760]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on all shifts.

Rationale and Summary
A resident was exhibiting active respiratory symptoms. The resident had been diagnosed with a respiratory infection and remained on precautions. A review of the documentation indicated that there was no record of any symptom monitoring of the resident on six shifts over a nine-day period.

The IPAC Lead stated that staff would document on the progress notes for a resident presenting with active symptoms of an infection. The IPAC Lead reviewed the information and confirmed that the noted days and shifts did not document any information about the resident's symptoms.

Failure to document a resident's active infection symptoms may lead to a delay in required treatments.

Sources: A resident's progress notes; Interview with the IPAC Lead. [760]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 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 the Director was immediately informed when an Acute Respiratory Infection (ARI) outbreak was declared at the home.

Rational and Summary
An ARI outbreak was declared by the local public health unit in the home. The CIS report was submitted to the Ministry of Long-Term Care (MLTC) four days later.

The Director of Care (DOC) #101 acknowledged the CIS should have been submitted immediately to Ministry of Long-Term Care (MLTC).

Failure to immediately inform the Director of the COVID-19 outbreak may have delayed follow up by the Ministry of Long-Term Care.

Source: CI 3006-000001-24, Interview with DOC #101. [000708]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.

The licensee has failed to ensure that an Agency PSW received mandatory training related to falls management prior them working in the home.

Rationale and Summary:
A CIS report was submitted by the home related to a resident's fall. The Agency PSW was involved directly with this incident. The DOC stated that the home relied on the staffing agency to review mandatory policies and procedures with their contracted staff members before they work in the home. However, the DOC stated that the home does not keep records of this information. The DOC was unable to provide records or evidence to support that this Agency PSW received mandatory training related to falls management prior to them working in the home.

Failure to ensure that the Agency PSW received mandatory education related to falls management prior to them working in the home may resulted in them not becoming aware of the home's policies and procedures leading to potentially compromising the resident's health and wellbeing.

Sources: Interviews with an RN, the DOC; A resident's progress notes. [760]