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: September 19, 2024

Inspection Number: 2024-1503-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Unity Health Toronto

Long Term Care Home and City: Providence Healthcare, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-16, 19-23, 26-27, 2024.

The inspection occurred offsite on the following date(s): August 29, 2024.

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:
Intake: #00122954 - 3006-000032-24 - related to a fall of a resident resulting in injury
Intake: #00123472 - 3006-000034-24 - related to improper care of a resident

The following intake(s) were inspected in the Complaint Inspection:
Intake: #00112914 - related to nutrition

The following intake(s) were completed in the CIS Inspection:
Intake: #00120601 - 3006-000028-24, Intake: #00121284 - 3006-000030-24 - related to a fall of a resident resulting in injury

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 logo that indicated high risk for falls was in place as specified in their plan of care.

Rationale and Summary

A logo that indicated high risk for falls was not observed to be in place. Staff

confirmed that there was no logo in place and that it should have been in place as the resident was at high risk for falls. On the same day, a staff member was observed putting the logo in place.

Failure to ensure that the logo that indicated high risk for falls was in place for the resident could lead to staff being unaware of the resident's risk for falls.

Sources: observation of a resident's room; interviews with the staff and management at the home.

Date Remedy Implemented: August 15, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that staff documented the provision of the care set out in the plan of care for a resident when their portable medical device ran out of battery power.

Rationale and Summary

A resident's medical device ran out of power. An individual who was present at the time, notified the staff. The resident was subsequently switched to a spare medical device. The resident was reported to have had a change in their health status at the

time of the incident.

A review of the resident's clinical records indicated that there was no documentation of the provision of care for the incident. The Director of Care (DOC) and a Clinical Operations Lead (COL) indicated that the incident should have been documented by the registered staff.

The home's failure to ensure that the incident was documented could lead to the home's inability to be aware of the incident and to follow up appropriately.

Sources: Interview with the home's staff and management; review of a resident's clinical record.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from neglect by staff on a Resident Home Area (RHA).

Section 7 of the Ontario Regulation 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 ordered a medical intervention for comfort. The resident's medical device was not in service, and as a result, the resident was provided with another medical device to use, which they were not assessed for.

Staff had notified the registered staff to contact the vendor during the day shift, which was not completed. During the evening shift that same day, the resident's medical device ran out of battery power. An individual who was present at the time, immediately notified the staff, and the resident was switched to a spare medical device. The resident experienced a health status change as a result. The vendor was notified later by the evening staff, and the resident was then provided with a new medical device.

The DOC indicated that the vendor assesses a resident for the qualification for use of medical devices when a physician orders the medical intervention for a resident. They indicated that staff should have utilized the spare medical device for the resident instead of the portable medical device to use overnight. DOC and COL confirmed that the RN should have contacted the vendor when they were informed by the RPN. However, the vendor was contacted only after staff were informed of resident's changes in health status. In addition, the nursing staff were responsible for monitoring and ensuring there was sufficient battery power for the medical device provided to the resident, and it should not have run out of battery power.

The staff failed to ensure that the resident was assessed for the use of a portable medical device and to provide the appropriate equipment when their medical device was not in service. Staff did not communicate with the vendor in a timely manner to ensure the resident's equipment was serviced and failed to monitor the battery power of the medical device, resulting in the change in the resident's health

status.

Sources: Interview with the home's staff and management, a resident's clinical record, critical incident report.

COMPLIANCE ORDER CO #001 Food production

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit, and implement a plan to ensure there is a standardized approach for the preparation of menu items in the home for residents on a specific texture diet in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. Specifically, the plan must include, but is not limited to, the following:

1. How the home will review current menus and implement a standardized approach for the preparation and serving of all menu items, including personalized menus, for residents on a specific texture diet in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

2. Training to all direct care nursing and dietary staff (including, but not limited to, Registered Nurses, Registered Practical Nurses, Resident Assistants, Cooks, and

Dietary Aides) on the preparation and serving of all menu items for a specific texture diet so that they meet the requirements of the home's new standardized approach as per step 1 of this order;

3. Maintain a record of the training from step 2, including the date, the content of the training, who conducted the training, and the name of the staff who received the training.

4. Conduct weekly random audits on all home areas for a minimum period of three weeks to ensure that staff are preparing and serving menu items as per the new standardized approach for the preparation of all specific texture diets for residents.

5. Maintain a record of the audits from step 4, including the date, the focus of the audit, who conducted the audit, the name of any staff and/or resident(s) being audited, and the results of each audit and actions taken in response to the audit findings.

6. The person(s) who will be responsible for steps 1 through 5 and when it will be completed, if applicable.

Please submit the written plan for achieving compliance for inspection #2024-1503-0003 to LTC Homes Inspector, MLTC, by email by October 4, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

This plan shall be implemented by the compliance due date: October 28, 2024.

Grounds
The licensee has failed to ensure that there was a standardized approach in the

preparation and serving of chopped-up menu items for a resident.

Rationale and Summary

A resident was provided meal service in their room as they were on isolation.

A resident's diet order at the time of the incident indicated that they were on a specified texture diet and must be fully supervised. The resident was served an item that was required to be "chopped up". A Resident Assistant (RA) indicated they had prepared the menu items and placed the meal in front of the resident with a drink.

The resident initially grabbed some of the menu items with their hands and ate them rapidly. The resident became subsequently restless, and staff immediately notified the registered staff, as they believed that the resident appeared to be in distress. The resident was later pronounced deceased by the physician.

The resident's personal menu at the time of the incident indicated the resident was to be served a menu item that was specified to be "chopped up". In addition, there were other menu items that were required to be "chopped up" on the personalized menu.

RA confirmed they did not receive any training related to serving the specific menu item specified to be “chopped up” for a resident on a specific texture diet. The Registered Dietitian (RD) indicated the home is unable to ensure consistency with the preparation of specific texture menu items by RAs as the home did not have a standardized approach at the time of the incident.

The home failed to ensure that there was a standardized approach in the preparation of menu items for residents on a specific texture diet. There was no

standardized approach for staff to "chop up" menu items to meet the specific texture, which increased the risk of staff preparing and serving the inappropriate texture of menu items to residents on a specific texture diet.

Sources: Interview with the home's management and staff, critical incident report, the home's therapeutic menu, a resident's clinical record, home's investigation notes, observation of a menu item at the home

This order must be complied with by October 28, 2024

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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

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.