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
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Original Public Report

Report Issue Date: July 19, 2024

Inspection Number: 2024-1503-0002

Inspection Type:
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): July 5, 8-12, 2024

The following intake(s) were inspected:

- Intake: #00112047/Critical Incident (CI) #3006-000011-24 - related to falls prevention and management
- Intake: #00112357/CI #3006-000014-24 - related to the unexpected death of a resident
- Intake: #00112944/CI #3006-000015-24 - related to a disease outbreak
- Intake: #00115584/CI #3006-000021-24 - related to the prevention of abuse and neglect
- Intake: #00117291/CI #3006-000024-24 - related to potential improper care/unknown cause of injuries sustained by a resident

The following intake(s) were completed:

- Intake: #00112049/CI #3006-000012-24 - related to a disease outbreak

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

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 high falls risk interventions for a resident were implemented as outlined in the plan of care.

A resident's equipment were observed to be without a falls logo affixed. The resident's care plan indicated that they were at risk for falls and required the falls logo to mitigate the risk for falls. Interview with a Registered Practical Nurse (RPN) admitted that falls interventions were not in place and acknowledged the falls logo should have been present for the resident.

During another observation, the inspector noted the falls logo were present for the resident.

Failure to ensure the high falls risk logo was present may lead to increased risk of falls for the resident.

Sources: Observations on specific dates and interview with a RPN.

Date Remedy Implemented: July 9, 2024.
[000859]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (e)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(e) a hand hygiene program; and

The licensee has failed to ensure that monthly hand hygiene audit record was maintained from April 2024 to June 2024.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to include a hand hygiene program in the Infection Prevention and Control (IPAC) program that provided strategies to prevent, monitor and reduce the transmission of infections and must be complied with. Specifically, the IPAC practitioner did not comply with the home's Policy and Procedures for Hand Hygiene for all Staff (# UHT0002130,

effective date October 13, 2023) to document hand hygiene compliance data.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, s. 10 (4) (d) stated that the licensee shall ensure the home's hand hygiene program to include monthly audit of adherence to the four moments of hand hygiene by staff. The home's hand hygiene policy directs the home's infection and prevention control service to document hand hygiene compliance data using a validated tool.

The IPAC Lead stated that they had been conducting monthly hand hygiene audits. However, they did not maintain a record of the audits or document any audit data as the home had been developing a new audit tool for hand hygiene practices since April 2024.

The Director of Care (DOC) acknowledged that the IPAC Lead should have kept monthly hand hygiene audit data and record to demonstrate the completion of the audits despite the home was in the process of developing a new audit tool.

Failure to maintain monthly hand hygiene audit record may hinder the home's analysis and evaluation of staff's hand hygiene practices.

Sources: The home's hand hygiene audit record, the home's Policy and Procedures for Hand Hygiene for all Staff (# UHT0002130, effective date October 13, 2023), interviews with the IPAC Lead and DOC.
[000757]

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 physical abuse by a staff.

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

On a specific date, a resident reported that a staff hit them during care and the incident was witnessed by a Resident Assistant (RA). The RA verified that they witnessed a staff strike the resident and the resident screamed. The resident expressed that they experienced pain as a result of the physical force used against them.

The DOC stated that physical abuse to the resident was substantiated through the home's investigation.

Failure to protect the resident from physical abuse from staff put the resident at risk for harm and injuries.

Sources: Home's investigation notes, interviews with the resident and staff. [000757]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy on zero tolerance to abuse and neglect was complied with by staff.

Rationale and Summary
On a specific date, a resident reported an alleged physical abuse incident to a RPN. The resident's clinical records did not show any documentation on the resident's condition or the details of the alleged physical abuse after the incident was reported to registered staff.

The RPN stated that they checked the resident's condition after the report of the incident but did not complete a head-to-toe assessment or document any assessment findings.

The home's policy on zero tolerance of abuse and neglect directs staff to check the resident's condition post any alleged/suspected/witnessed abuse incident and to document the details of the incident immediately.

The DOC acknowledged that the RPN did not comply with the home's policy as they

failed to document the details of the reported physical abuse and any assessment of the resident's condition.

Sources: A resident's clinical records, the home's policy on Zero Tolerance of Abuse and Neglect Policy (Policy#: HP020, last reviewed/revised: May 29, 2024), interviews with a resident and staff.
[000757]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an alleged staff to resident physical abuse incident was immediately reported to the Director.

Rationale and Summary
A CI report regarding staff to resident abuse was submitted to the Director one day after it was reported by staff. Both the RPN and DOC acknowledged that the incident should have been reported immediately to the Director through the Service Ontario After-Hours Line.

Failure to immediately report allegations of abuse to the Director may have delayed

the Director's ability to respond to the incident in a timely manner.

Sources: CI report 3006-000021-24, home's investigation notes and interviews with staff.
[000757]

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that a clinically appropriate pain assessment tool was used for a resident when they experienced pain.

Rationale and Summary
A resident sustained injuries and had experienced ongoing pain.
According to the home's policy, a pain assessment was to be completed on PointClickCare (PCC) when a resident exhibited a change in health status or if pain is not relieved by initial interventions.

A review of the assessments on PCC did not demonstrate that the pain assessment tool was utilized after the resident sustained injuries with pain.

DOC #109 stated that there was a specific tool under the assessments tab on PCC that should have been utilized in this situation.

Failure to ensure that a clinically appropriate tool was utilized to conduct pain assessments on this resident may have led to missed opportunities in implementing pain interventions.

Sources: A resident's clinical records; Home's policy, "Houses of Providence- Pain Management", dated July 21, 2021 and interviews with staff.
[760]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (d) stated that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary

A PSW student wearing full PPE was observed to be inside a resident room who was on identified precautions. Prior to exiting the resident room, the PSW student removed the gloves, face shield and gown then disposed these into the receptacle outside of the resident room. The PSW student then performed hand hygiene. The PSW student was observed to have exited the resident room without removing the surgical mask and proceeded to interact with another staff and engaged in various activities down the hallway.

The PSW student acknowledged that they should have doffed the contaminated mask prior to exiting the resident room. The DOC verified that all staff to doff all contaminated PPEs prior to exiting a resident room who was on identified precautions.

The DOC acknowledged there was a risk of transmission of infection when contaminated PPEs were not removed.

Sources: Observation on a specific date, and interviews with the PSW student and the DOC.
[000757]