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 9, 2024
Inspection Number: 2024-1503-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: Unity Health Toronto
Long Term Care Home and City: Providence Healthcare, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25-29, 2024 and December 2-4, 2024.

The following intake(s) were inspected:

- Critical incident (CI) 3006-000037-24 - related to an injury of unknown cause.
- Complaint related to potential improper care and consent.
- CI 3006-000039-24 - related to a disease outbreak.
- Follow-up to Compliance Order (CO) #001 related to food production.
- CI 3006-000046-24 - related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1503-0003 related to O. Reg. 246/22, s. 78 (2)

(d)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 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 failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented as it pertained to minimum routine practices.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), under section 9.1(b), routine practices shall include at minimum, hand hygiene, including, but not limited to, the four moments of hand hygiene. Specifically, a staff member failed to adhere to the

four moments of hand hygiene when moving between resident environments.

Rationale and Summary

Staff were observed serving snacks to residents without performing hand hygiene between resident environments.

The IPAC Lead indicated that entering a resident environment without performing hand hygiene is not compliant with the four moments of hand hygiene and increases the risk of transmission.

Failure to perform hand hygiene between resident environments may potentially increase the risk of infection transmission.

Sources
Observations; interviews with staff.

COMPLIANCE ORDER CO #001 Administration of drugs

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Re-educate the Registered Practical Nurse (RPN) on the home's Medication

Administration policy and procedure related to reviewing medication orders and administering medications as per the eMAR (Electronic Medication Administration Record).

2) Review the College of Nurses (CNO) Medication Practice Standard with the RPN to ensure that they are aware of their accountabilities when engaging in medication practices, that they have the knowledge, skill, and judgment needed to perform medication practices safely; and that when reviewing a medication order that is unclear, incomplete, or inappropriate, the nurse must not perform the medication practice and must follow up with a prescriber in a timely manner.

3) Maintain a record of the training from steps 1 & 2, including the date, the content of the training, who provided the training, and the name of the staff who received the training.

Grounds

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber. A resident was incorrectly administered a medication.

Rationale and Summary

An RPN administered a medication to a resident. Immediately after administration, the RPN called a Registered Nurse (RN) to verify the medication order. The RN determined that the RPN had misread the medication order and should not have administered the medication. Subsequently, the physician and substitute decision-maker were notified, and the resident was transferred to the hospital for treatment.

The RPN and Director of Care (DOC) indicated that RPN should not have administered the medication to the resident. The DOC indicated that it was life

threatening to the resident if the incident had not been identified and the home had not intervened in a timely manner.

When the RPN incorrectly administered the medication, the resident required hospitalization for treatment.

Sources: Resident clinical record, home's investigation notes, interview with the home's staff and management.

This order must be complied with by January 20, 2025

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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
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
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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.