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

Public Report

Report Issue Date: February 12, 2025

Inspection Number: 2025-1503-0001

Inspection Type:
Other
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): February 3-4, 6-7, 10-12, 2025

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00132031 - CI #3006-000049-24 was related to Fall Prevention and Management
- Intake: #00131005 - CI #3006-000048-24 and intake: #00134497 - CI #3006-000053-24 were related to Prevention of Abuse and Neglect
- Intake: #00134433 - CI #3006-000052-24 - was related to unknown cause of injury
- Intake: #00137100 - CI #3006-000002-25 was related to Continence Care and Bowel Management
- Intake: #00134852 - CI #3006-000055-24 was related to a disease outbreak
- Intake: #00139208 was related to Outstanding Emergency Planning Annual Attestation
- Intake: #00134068 - Follow-up on a previously issued Compliance Order (CO) related to Medication Administration

The following intakes were completed in this CI inspection:

- Intake: #00134425 - CI #3006-000051-24 was related to unknown cause of injury
- Intake: #00137642 - CI #3006-000003-25 was related to a disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1503-0004 related to O. Reg. 246/22, s. 140 (2)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed. The resident had a fall, and sustained an injury. The resident's fall prevention interventions were no longer suitable to the resident and their care plan was not revised accordingly.

Sources: The resident's clinical record, observation and interview with the Falls lead.

[000860]

WRITTEN NOTIFICATION: Duty to protect

NC #002 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 emotional and verbal abuse by a staff member.

Section 2 of Ontario Regulation 246/22 defines the types of "abuse", as the following,

"emotional abuse" any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;

"verbal abuse" any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Resident Assistant (RA) had an altercation with a resident which made them upset and diminished their sense of dignity and self-worth. The Director of Care (DOC) stated that the staff's behavior was unprofessional and unacceptable, confirming the allegations of verbal and emotional abuse.

Sources: Resident's clinical records, CI report, Home's Internal Investigations records, Video footage, Home's Policy, Zero Tolerance to Abuse and Neglect, Interviews with staff.

[741150]

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 3.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The licensee failed to adhere to the home's 'Continence Care and Bowel Management' policy when continence monitoring was not completed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to comply with the home's Continence Care and Bowel Management policy related to the

bowel and voiding monitoring and reporting concerns or changes to the Registered Nurse (RN) or Registered Practical Nurse (RPN).

Specifically, a RA did not monitor a resident's urine output, which led to them not noticing that the resident did not void during their shift. As a result, the concern was not reported to the registered nurse.

Sources: Resident's clinical notes, interview with a RA and a RPN, "Continence Care and Bowel Management" policy.

[741672]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #004 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 failed to ensure that the fall prevention and management program was implemented related to the use of fall prevention equipment for a resident. The resident had a history of fall and had fall prevention equipment in their plan of care. However, the fall prevention equipment was not implemented for the resident while the resident experienced multiple falls.

Sources: Resident's clinical records and interview with a RA and the Falls lead.

[000860]

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Sources: The resident's clinical record, interview with the falls lead.

[000860]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident was found with an area of altered skin integrity, they received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Sources: The resident's clinical records, interview with a RPN and the Clinical Operational Lead.

[000860]

WRITTEN NOTIFICATION: Cleaning of Shared Equipment

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
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:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee failed to clean and disinfect a shared equipment with a low-level disinfectant.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that their required policies are complied with. Staff did not comply with the Home's policy, "Routine Practices and Additional Precautions".

A RA brought out a cart carrying a ceiling lift from a room on additional precautions and did not disinfect it. The IPAC Lead acknowledged that staff are required to disinfect all shared equipment.

Sources: An observation, Routine Practices and Additional Precautions, interview with the IPAC Lead.

[000825]

WRITTEN NOTIFICATION: Symptom Monitoring

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection for a resident were monitored and recorded.

During the period that a resident was exhibiting signs of infection, documentation was missing for multiple shifts.

The IPAC Lead acknowledged that staff are expected to monitor resident symptoms each shift and record this in their progress notes.

Sources: The resident's clinical records; interview with the IPAC Lead.

[000825]

WRITTEN NOTIFICATION: Emergency Plans

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure that the emergency planning attestation form was submitted annually to the Director. The administrator confirmed that they did not submit the emergency planning attestation form to the director by the due date.

Sources: Interview with the administrator

[741672]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Provide education to all staff on one of the resident home areas on hand hygiene expectations during meal service.
2. Provide education to a RA on best practices for appropriately doffing PPE.
3. Provide education to all staff on proper use of the hand sanitizer wipes for resident hand hygiene, in accordance with the manufacturer's instructions.
4. Maintain a record of education from steps 1-3, including the content of the education, the date, the staff members who received the education, and the staff member(s) who provided the education.

Grounds

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

i. Specifically, section 9.1 (b) states "at minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact)".

During a meal service, two RAs, and an Activation Assistant entered and exited designated home area without performing hand hygiene. Additionally, a RA assisted a resident with cleaning their hands with a sanitizing hand wipe, and did not perform hand hygiene following contact with the resident.

Failure to follow routine practices placed residents at risk of exposure to infectious agents and contracting an infectious disease.

Sources: An Observation, 2025; Policy and Procedure for Hand Hygiene for All Staff,

Interviews with two RAs, an Activation Assistant and the IPAC Lead.

ii. Specifically, section 9.1 (f) states "at minimum, additional precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal".

After exiting a resident's room on additional precautions while wearing PPE, a RA did not perform hand hygiene or doff their PPE appropriately.

Failure to doff PPE appropriately placed staff at risk of contaminating themselves and at risk of transmitting infectious agents.

Sources: An observation, interview with the IPAC Lead; Policy and Procedure for Hand Hygiene for All Staff.

iii. Specifically, section 10.2 states "the licensee shall also ensure that the hand hygiene program for residents has a resident-centered approach with options for residents, while ensuring that hand hygiene is being adhered to".

Staff assisted residents with their hand hygiene using hand sanitizer wipes. The instructions on the packaging stated that the wipes must be used for a specified amount of time. However, resident hand hygiene with the wipes was timed and staff did not follow the manufacturer's instruction of 30 seconds.

The IPAC Lead acknowledged that staff were expected to use the wipes for 15 seconds on each hand for a total of 30 seconds as per the manufacturer's instruction.

Failure to use the hand wipes as per manufacturer's instruction creates risk of bacteria remaining on resident hands and the transmission of infectious agents.

Sources: An observation, interview with the IPAC Lead.

[000825]

This order must be complied with by March 24, 2025

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
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.