

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: May 13, 2025

Inspection Number: 2025-1503-0003

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): April 15-17, 22, 24, 25, 28-30, 2025 and May 1, 2, 6, 7, 2025

The inspection occurred offsite on the following date(s): April 28, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00133888 – [CI: 3006-000050-24] – Staff to resident neglect and emotional and verbal abuse
- Intake: #00140487 – [CI: 3006-000005-25] – Staff to resident physical abuse
- Intake: #00142080 – [CI: 3006-000011-25] – Improper care related to feeding and positioning
- Intake: #00142405 – [CI: 3006-000013-25] – Improper care and resident neglect
- Intake: #00142512 – [CI: 3006-000016-25] – Fall with injury
- Intake: #00143305 – [CI: 3006-000024-25] – Improper care related to transferring
- Intake: #00144512 – [CI: 3006-000026-25] – Infection prevention and control

The following complaint intake(s) were inspected:

- Intake: #00143058 – Resident nutrition and hydration

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The following follow-up intake(s) were inspected:

- Intake: #00139888 – Infection prevention and control

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

- Intake: #00141809 – [CI: 3006-000007-25], intake: #00142102 – [CI: 3006-000009-25], intake: #00142528 – [CI: 3006-000017-25], intake: #00142857 – [CI: 3006-000020-25]. Intake: #00143232 – [CI: 3006-000023-25] – Infection prevention and control

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1503-0001 related to O. Reg. 246/22, s. 102 (2) (b).

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that a Registered Nurse (RN) #110 and others involved in the different aspects of a resident's care collaborated with each other in the assessment of the resident.

A RN administered an incorrect type of nutritional supplement to the resident.

The RN neither reassessed the resident's status nor monitored the resident after the error, nor endorsed in writing for the next shift. They also did not relay the incident to the physician for directions.

The RN provided verbal report to another RN regarding the incident, who did not inform the Registered Practical Nurses (RPNs) of the incident. The Clinical Operational Lead (COL) and Director of Care (DOC) indicated that the RN did not collaborate with the team in the assessment of the resident.

Sources: Resident's clinical records; home's investigation notes; home's Enteral Tube Feeding policy (Document #UHT0000977; last revised May 2, 2022); and interviews with a RPN, RNs, COL and DOC.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

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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 to immediately forward to the Director any written complaint that it received concerning the care of a resident or the operation of a long-term care home for multiple incidents. Eight written complaints submitted via email concerning a resident's care in the home were not forwarded to the Director.

The COL and DOC indicated eight written complaints were not forwarded to the Director.

Sources: Resident's clinical records; Home's investigation notes; and interviews with COL and DOC.

WRITTEN NOTIFICATION: Reporting certain matters to director

NC #003 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 has failed to ensure that improper or incompetent treatment or care

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of a resident that caused harm or risk of harm was immediately reported to the Director.

i) An incident of suspected improper care of a resident occurred. The Ministry of Long-Term Care's (MLTC) After Hours pager was not contacted. The Critical Incident (CI) report was first submitted to the MLTC several days later.

Sources: CI #3006-000011-25; and interview with COL.

ii) A resident was improperly transferred resulting in an injury. Staff members involved in care did not report the incident. The resident reported the incident to the physician who documented the improper transfer incident in the resident's progress notes on Point Click Care. The home did not submit the CI report until one week later. The DOC acknowledged that the CI was not submitted on time.

Sources: CI Report; CI Investigation Notes; resident's clinical records; Zero Tolerance for Abuse and Neglect Policy, Document #: UHT0000384, Last Revised: April 26, 2023; interviews with RAs, DOC, and the resident.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 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 has failed to ensure that staff used safe transferring techniques when assisting a resident.

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A resident required a specific intervention for all transfers. A Resident Assistant (RA) did not use the intervention to transfer the resident, resulting in the resident sustaining an injury. The RA did not use safe transferring techniques when assisting the resident.

Sources: CI Investigation Notes; interviews with RAs, DOC, and the resident.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident, who required continence care products had sufficient changes to remain clean, dry and comfortable. The resident was not changed for several hours when their brief and bed linens were soiled.

Sources: Resident's clinical records; home's investigation notes; and interviews with a RPN and DOC.

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

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appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident was administered a pain intervention which was determined to be ineffective with the resident continuing to experience pain. No pain assessment was completed for the resident.

Sources: Resident's clinical records; Pain Management Policy, Document #: HP052, last revised: July 27, 2021; interview with DOC.

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 (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 has failed to ensure that a resident's symptoms were recorded on each shift when they were demonstrating signs of infection. The resident's symptoms were not documented on multiple shifts when they were on droplet/contact precautions.

Sources: Resident's clinical records; and interview with IPAC Practitioner.

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WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a resident's topical medication was stored in an area that was secure and locked, when it was found on the resident's bed. The DOC confirmed the medication should have been returned to the medication cart after use.

Sources: Observations; resident's clinical records; and interview with DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Provide re-education to all nursing staff (Resident Assistant (RA), Registered Practical Nurse (RPN), and Registered Nurse (RN)) that were assigned to a specific resident home area on both day and evening shift of an identified date, on resident#004's plan of care related to positioning during feeding, and safety risks of improper positioning.

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2. Provide re-education to all nursing staff (RA, RPN, RN) on the Poplar resident home area on resident #001's plan of care related to positioning during a specified feeding, and safety risks of improper positioning.

3. Provide re-education to RN #110, RN #135, RPN #136, and all registered staff (RPN and RN) on a specific resident home area on resident #001's plan of care regarding feeding. The education should include but not be limited to: the resident's formula order, initiating a feed, procedure and interventions ordered for the resident.
4. Maintain a written record of the education; including attendance, date and time, who provided the education, and topics covered in the education
5. Conduct two audits weekly on day and evening shifts for a period of three weeks of resident #004's positioning during feeding. If resident #004 is not available, select another resident that requires the specified nutrition for the audits.
6. Conduct two audits weekly for a period of three weeks of resident #001's positioning during feeding. If resident #001 is not available, select another resident that requires enteral nutrition for the audits. The audits of resident #001 must be conducted at minimum once on each shift (day, evening and night).
7. Maintain a written record of audits, including the dates, who conducted audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds

- i) The licensee has failed to ensure that resident #004's plan of care related to positioning during feeding was followed.

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Rationale and Summary

Resident #004's head of bed (HOB) was required to be elevated while the resident was receiving nutrition as per their plan of care. A RPN found the resident in an incorrect position with a significant change in status, requiring hospitalization.

The RPN confirmed that resident #004 was unable to reposition themselves and that the HOB should have been elevated.

Failure to ensure that resident #004's HOB was elevated as specified in their plan of care while receiving nutrition resulted in transfer to the hospital due to a significant change in status.

Sources: Resident #004's clinical records; home's investigation notes, and interviews with a RPN and COL.

ii) The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

(1) Resident #001's head of bed (HOB) was required to be elevated. On multiple dates, staff failed to ensure the resident's HOB was elevated as per their plan of care.

The COL indicated that resident #001 was at risk of aspiration and required their HOB to be elevated. They indicated that staff did not position the resident's HOB as per their plan of care.

Failure to ensure that resident #001's HOB was elevated as specified in their plan of care led to increased risk of harm.

(2) Resident #001 was to receive a specific intervention before and after medication

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administration and feeding, as per their plan of care. On several identified dates, multiple staff members failed to follow the plan of care.

The COL indicated the interventions were required, and acknowledged the resident's plan of care was not followed.

Failure to provide the interventions as specified in put the resident at risk of increased harm.

(3) Resident #001 was to receive a specific nutritional supplement as per their plan of care. On multiple dates, the resident did not receive the correct amount of supplement, and also was administered the incorrect supplement.

The COL indicated that the registered staff should have reviewed the nutritional supplement to ensure it was administered appropriately.

Failure to provide resident #001 with the correct amount of nutritional supplement, as well as the correct formula as specified in their plan of care put resident #001 at risk of not receiving appropriate nutrition and hydration.

Sources: Resident #001's clinical records; home's investigation notes; home's Enteral Tube Feeding policy (Document #UHT0000977; last revised May 2, 2022); and interviews with Registered Dietitian (RD) and COL.

This order must be complied with by June 18, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

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The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order related to FLTCA, 2021, s. 6 (7) was issued on 2022-12-16 in inspection #2022-1503-0002

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Duty to protect

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NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

1. Provide education to Resident Assistant (RA) #113 on the licensee's policy and expectations for the implementation of resident care plans, with a specific focus on transfers methods and devices.
2. Provide education to RA #113 and RA #115 on the home's abuse and neglect policy, with a specific focus on their duty to report improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident.
3. Provide education to all registered staff on a specified resident home area on the home's policy and expectations for monitoring and assessment of residents' pain and pain interventions.
4. Maintain a record of the education from steps 1-3, including the content of the education, the date, the staff member(s) who received the education, and the staff member(s) who provided the education.

Grounds

The licensee has failed to ensure that resident #003 was not neglected by the licensee or staff.

In accordance with the definition identified in Ontario Regulation 246/22 section 7, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes the inaction or a pattern of inaction that jeopardizes the health, safety or well-being.

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Rationale and Summary

A resident sustained an injury after an improper transfer by staff, which was not reported to registered staff, and subsequently the resident's pain was not adequately treated or monitored.

i) Two staff members did not safely transfer a resident who required assistance, resulting in an injury and pain.

The staff members did not report the incident to anyone during the shift. The resident stated that they were in pain following the incident, and believed that the staff would report the incident. When the resident realized that other staff were unaware of the incident, they reported it to the physician the following day.

The staff members did not immediately report the improper transfer incident, which prevented the home from taking immediate action and appropriately monitoring and treating the resident's pain.

ii) The resident reported to a RPN that they had pain. The RPN administered pain medication and documented to "continue to monitor". The resident was only administered pain medication once over the next several days. No other documentation of monitoring or assessment of the resident's pain was identified.

The resident continued to experience significant pain for additional days afterwards.

Failure to report a potential injury to the resident and consistently monitoring and treating their pain, resulted in the resident experiencing breakthrough pain and delayed treatment.

Sources: Resident's clinical records; CIS investigation notes; Zero Tolerance for Abuse and Neglect Policy, Document #: UHT0000384, Last Revised: April 26, 2023;

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interviews with RAs, DOC and the resident.

This order must be complied with by June 18, 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

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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

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Director

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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.