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

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Public Report

Report Issue Date: June 23, 2025

Inspection Number: 2025-1503-0004

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): June 12-13, 16-18, 20, 23, 2025

The following complaints were inspected:
· Intake: #00145499, intake: #00146679 and intake: #00147493 – complaints related to resident care and services

The following follow-up intake(s) were inspected:
· Intake: #00146930 - follow-up on a previously issued Compliance Order (CO) related to plan of care
· Intake: #00147429 - follow-up on a previously issued CO related to prevention of abuse and neglect

The following critical incidents (CI) were inspected:
· Intake: #00147760: CI #3006-000041-25 – related to unknown cause of injury
· Intake: #00147408/CI #3006-000036-25 and intake: #00150272/CI #3006-000047-25 were related to disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1503-0003 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2025-1503-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out the planned care for the resident. The resident required the use of a specific equipment which was not included in their plan of care.

The resident's plan of care was updated to include this intervention at a later date.

Sources: Resident's clinical records, interviews with the resident, Resident Assistant (RA) and Registered Practical Nurse (RPN).

Date Remedy Implemented: June 16, 2025

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) 3.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
3. The effectiveness of the plan of care.

The licensee has failed to ensure the effectiveness of the trial of an intervention for a resident was documented.

The resident's plan of care showed the intervention was implemented over a three-week period

The Director of Care (DOC) confirmed there was no documentation to demonstrate the effectiveness of the plan of care related to the trial.

Sources: Resident's clinical records and interviews with DOC.

WRITTEN NOTIFICATION: Doors in a Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the laundry room door on a Resident Home Area (RHA) was kept closed and locked when not being supervised by staff.

An object was used to keep the laundry room door open when not in use. There were two residents in their rooms in front of the laundry room and no staff members were present.

Sources: Observation on a RHA, interview with DOC.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure pain assessments were completed for a resident when they exhibited a change in health status and upon readmission to the home.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a pain management program to identify and manage pain in residents, and must be complied with. Specifically, registered nursing staff did not comply with the home's policy to complete pain assessments when the resident was experiencing pain.

Sources: Resident's clinical records, home's Pain Management policy (HP052, last reviewed: July 27, 2021), interviews with RPN and the DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 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 the Infection Prevention and Control (IPAC)

Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 (f) additional precautions shall include, additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal. under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023).

A housekeeping staff did not remove PPE appropriately. The housekeeping staff removed their gloves, then their gown and then donned another pair of gloves when exiting the room of a resident on Droplet Contact Precautions (DCP) on an outbreak unit.

Sources: Inspector's observation; "IPAC Standard for Long-Term Care Homes, April 2022", interview with housekeeping manager and DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the home’s Infection Prevention and Control (IPAC) Program when a staff member

was observed not wearing a surgical mask correctly. At the time of this observation, a mandatory masking policy was in effect.

Sources: Observations on a resident home area; 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)
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
(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 resident's symptoms indicating the presence of infection were monitored every shift and that immediate actions were taken to reduce transmission and isolate the resident.

The resident exhibited symptoms of infection on a particular date. Their symptoms were not monitored consistently on every shift over the next week. They were not placed on additional precautions until several days later, which was acknowledged by the IPAC lead.

Sources: Review of Toronto Public Health (TPH) Outbreak Line List, resident's

clinical records; and interview with the IPAC lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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 has failed to ensure that three residents' symptoms indicating the presence of infection were monitored every shift when they were on droplet/contact precautions. The IPAC lead acknowledged that symptoms were required to be monitored on every shift.

Sources: Review of TPH's Line List, residents' progress notes and vitals; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health

Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) were complied with. The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective February 2025, required that the home to refer to manufacturer’s instructions for use of cleaning products and disinfectants.

The inspector observed an expiration date on a cleaning product used to clean a resident's room that was under additional precautions.

Sources: Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective February 2025; Interviews with housekeeping staff, Housekeeping Manager and DOC.