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: August 7, 2025
Inspection Number: 2025-1503-0005
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 dates: August 5, 6, 7, 2025.

The following intakes were inspected:

- Intake: #00150690- Critical Incident System (CIS) # 3006-000048-25 related to a communicable disease outbreak;
- Intake: #00148344- CIS # 3006-000044-25 related to a fall with an injury

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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 a Resident Assistant (RA) and a Registered Practical Nurse (RPN) utilized safe transferring techniques after a resident sustained a fall. After the RPN's assessment, staff members assisted the resident with transferring. The Director of Care (DOC) stated that in this incident, staff did not utilize safe transferring techniques with the resident that aligned with their training.

Sources: Home's policy titled, "Falls Prevention and Management", dated March, 2022; Interview with a RA and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 implemented.

i). In accordance with the "IPAC Standard for Long Term Care Homes April 2022", under section 10.4, section H, residents shall receive support from staff to perform hand hygiene prior to receiving meals and snacks. A resident did not receive hand hygiene prior to them eating their lunch. The RA acknowledged that they forgot to ask the resident whether they had performed hand hygiene prior to receiving their lunch.

Sources: Observation in a dining room; Interview with the RA and the DOC.

ii). In accordance with the "IPAC Standard for Long Term Care Homes April 2022", under section 5.6, the licensee shall ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach. The Administrator confirmed that the home did not have policies and procedures in place that outlined the frequency of surface cleaning and disinfecting based on a risk stratification approach.

Sources: Review of various IPAC policies and procedures from the home; Interview with the Administrator.