Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: October 23, 2025
Inspection Number: 2025-1503-0006
Inspection Type:
Complaint
Critical Incident

Licensee: Unity Health Toronto
Long Term Care Home and City: Providence Healthcare, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 14-17, 20-23, 2025

The following intake(s) were inspected:

- Intake: #00155620 - complaint related to staff training, personal support services, pest control and housekeeping
- Intake: #00156585 - complaint related to the care of a resident
- Intake: #00160156/Critical Incident (CI) #3006-000064-25 - related to improper care of a resident

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Residents' Rights and Choices

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 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident’s written plan of care set out clear directions to staff and others who provide direct care to the resident. Specifically, there were no clear directions to registered nursing staff concerning a procedure. The instructions were later added to the resident’s plan of care after an incident occurred where a different method was used.

Sources: A resident’s clinical records and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan. A Registered Practical Nurse performed a procedure on the resident using different method than what the physician had ordered.

Sources: A resident’s clinical records and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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 of has failed to ensure that a staff used safe transferring techniques when

assisting a resident. A resident required two-person assistance with transfers. On a specific occasion, a Resident Assistant transferred the resident alone.

Sources: A resident's clinical records, home's transferring and positioning policy and interviews with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
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:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfecting the dining tables.

Sources: Observation and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident. A resident was administered a drug that was prescribed for another resident.

Sources: A resident’s clinical records and interviews with staff.