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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Original Public Report

Report Issue Date July 29, 2022
Inspection Number 2022_1503_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Unity Health Toronto

Long-Term Care Home and City
Providence Healthcare

Lead Inspector
Adelfa Robles (723)

Additional Inspector(s)
Noreen Frederick (704758)

Inspector Digital Signature
Adelfa P Robles
2022.07.29 13:04:37 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 12, 13, 14, 15, 18, 19 and 20, 2022

The following intake(s) were inspected:

- Log #011655-22 (Critical Incident System (CIS) #3006-000021-22) related to medication management
- Log #012883-22 (CIS #3006-000023-22) related to an injury of unknown cause
- Log #012506-22 (Complaint) related to multiple care concerns
- Log #021100-21 (Follow-up) related to transferring and positioning techniques

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 36	2021_938758_0004	001	704758

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that staff collaborated with the physician for assessment and treatment of a resident's oral health.

Rationale and Summary
A Registered Practical Nurse (RPN) was informed about a change in a resident's oral health. RPN did not collaborate with the physician for an assessment and did not implement any interventions. Physician stated that the resident most likely had an infection and was prescribed treatment if assessed. The Director of Care (DOC) indicated that registered staff were expected to collaborate with the physician to ensure that resident was assessed and treated.

When registered staff failed to collaborate with the physician in the assessment of a resident there was a risk of oral infection.

Sources:
Resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that two-person assistance with care for a resident was provided as specified in the plan.

Rationale and Summary
The home submitted a CIS when a resident sustained an injury and was transferred to hospital for further treatment.

A resident required two-person assistance for care. Resident Assistants (RAs) who worked with the resident reported that they all had provided one-person assistance during care. Clinical Operations Leads (COLs) stated that staff were expected to follow resident's plan of care.

A resident was not provided a two-person assistance for care as specified in their plan, placing them at risk for injuries.

Sources:
Resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION ADMINISTRATION, MISCELLANEOUS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 184 (3)

1. The licensee has failed to ensure that staff and visitors wore medical masks while indoors as required by a Minister's Directive.

Rationale and Summary
A visitor was observed without a mask while talking to a Registered Nurse (RN) in the hallway. An RPN had their mask on their chin while giving shift report to two RAs at the nursing station.

The DOC acknowledged that this practice was unacceptable, and all staff and visitors were expected to keep their mask on at all times.

Due to the home not ensuring that the universal masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources:
July 19, 2022, observations, Minister's Directive: COVID-19 response measures for long term care homes, published April 27, 2022, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 - June 27, 2022 and staff interviews.

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2. The Licensee has failed to ensure that registered staff assessed residents at least once a day for signs and symptoms of COVID-19.

Rationale and Summary
Residents were to be monitored for COVID-19 symptoms including atypical symptoms as per the home's COVID-19 monitoring checklist. RPNs who worked with the residents stated that there was no COVID-19 monitoring checklist and the residents were not monitored for signs and symptoms of COVID-19 except for their temperatures. COL acknowledged that residents' assessment for signs and symptoms of COVID-19 were not completed as required.

Due to the home not assessing residents for signs and symptoms of COVID-19, residents and staff were put at risk of transmitting COVID-19.

Sources:
Residents' Electronic Medication Administration Record (EMAR), Minister's Directive: COVID-19 response measures for long term care homes, published April 27, 2022, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 - June 27, 2022, and staff interviews.

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3. The Licensee has failed to ensure that screeners asked all the questions indicated in the home's COVID-19 active screening questionnaires.

Rationale and Summary
Observations of the home's active screening at entry identified that screener only asked one question when Inspector #705758 and Inspector #723 entered the home. Further observation of visitor active screening identified that another screener only asked one question to two visitors prior to their entry.

The home was using an outdated version of the Ministry of Health's COVID-19 Screening Tool for Long-Term Care and Retirement Homes. Their version was missing question #6 related to isolation requirement if living with someone positive for COVID, had COVID symptoms and had pending COVID-19 test results.

COL acknowledged that all questions should be asked for symptoms and exposure history for COVID-19 before visitors were allowed to enter the home. Additionally, they acknowledged that the home should have been using the most up-to-date Ministry of Health's COVID-19 Screening Tool for Long-Term Care and Retirement Homes updated on June 27, 2022.

Due to the home not actively screening visitors for symptoms and exposure history for COVID-19 before they were allowed to enter the home and using an outdated screening tool residents and staff were put at risk of transmittable COVID-19.

Sources:
July 13, 2022, observations, Minister's Directive: COVID-19 response measures for long term care homes, published April 27, 2022, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 - June 27, 2022, Home's COVID-19 Active Screening Questionnaire and staff interviews.

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WRITTEN NOTIFICATION NURSING AND PERSONAL SUPPORT SERVICES

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 38 (1) (a)

The licensee has failed to ensure that a resident was provided oral care.

Rationale and Summary
Staff were to ensure that the resident received assistance from staff with their oral care needs. RAs who worked with the resident stated that they did assist the resident with oral care as required. Registered staff stated that this information was not communicated to them.

The DOC acknowledged that staff were expected to provide residents oral care as required.

Due to the home not ensuring that a resident received the assistance with oral care that they required there was a potential risk of the resident's oral tissue integrity to be compromised.

Sources:
Resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that a resident who exhibited altered skin integrity, was assessed by a registered dietitian of the home.

Rationale and Summary
The home submitted a CIS when a resident sustained a skin injury and was transferred to hospital for further treatment.

Houses of Providence-Skin Care and Pressure Injury Prevention Policy required registered staff to send referrals to the Registered Dietitian (RD) for residents identified at risk for altered skin integrity. A resident was not referred to the home's RD after sustaining a skin injury. Staff interviews stated that an RD referral was not completed for the resident.

The resident was not assessed by the home's RD to mitigate the risk of nutrition and hydration deficiencies to support stages of wound healing.

Sources:
House of Providence Skin Tear and Pressure Injury Policy, resident's clinical records and staff Interviews.

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WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
Houses of Providence-Skin Care and Pressure Injury Prevention Policy indicated that a resident with skin breakdown shall be assessed at a minimum weekly by a member of the registered nursing staff. A resident sustained a skin injury. The home completed Skin Tear Assessments on the date of injury and 11 days after. Staff interviews indicated that the resident's altered skin integrity was not assessed weekly as required.

A resident was not assessed at least weekly by a member of the registered nursing staff to mitigate further skin breakdown.

Sources:
House of Providence Skin Tear and Pressure Injury Policy, resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 102 (2) (a)

The licensee has failed to ensure surveillance protocols related to Rapid Antigen Test (RAT) issued by the Director for a particular communicable disease or disease of public health significance were complied with.

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Rationale and Summary
RA completed a RAT for a visitor entering the home. Inspector #704758 observed that a staff member did not follow the manufacturer's instructions on the Rapid Response COVID-19 testing device when they failed to keep the swab standing in the extraction tube for two minutes prior to dispensing into the testing device.

The DOC acknowledged that the manufacturer's instructions were not followed to ensure accuracy of the test results.

Due to home not following the RAT device's instructions, there was a risk to residents, staff and visitors related to spread of infectious disease.

Sources:
July 12, 2022, observations, Rapid Response COVID-19 Antigen Rapid Test Device manufacturer's instructions and staff interviews.

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