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

Toronto District
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Original Public Report

Report Issue Date: May 16, 2023

Inspection Number: 2023-1503-0004

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Unity Health Toronto

Long Term Care Home and City: Providence Healthcare, Scarborough

Lead Inspector	**Inspector Digital Signature**
Maya Kuzmin (741674)	Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.05.23 10:56:08 -04'00'

Additional Inspector(s)
Chinonye Nwankpa (000715)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17-21 and 24-25, 2023

The following intake(s) were completed in this complaint inspection:
- Intake 00085778 was related to resident care and support services

The following intake(s) were completed in this Critical Incident (CI) inspection:
- Intake: #00019977 was related to alleged staff to resident abuse and
- Intake: #00021886 was related to falls prevention and management

The following intake(s) were completed in this follow up inspection:
- Intake: #00016125 - Follow-up Inspection to a Compliance Order (CO) #001: FLTCA, 2021, s. 6 (7) – related to Plan of Care
- Intake: #00021434 - Follow-up Inspection to a Compliance Order (CO) #001: O. Reg 246/22, s.102(2) - related to Infection Prevention and Control Program

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order ##001 from Inspection #2022-1503-0002 related to FLTCA, 2021, s. 6 (7) inspected by Maya Kuzmin (741674)

Order #001 from Inspection #2023-1503-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Maya Kuzmin (741674)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of their Infection Prevention and Control (IPAC) program.

Rationale and Summary:

The home's policy on the appropriate use of surgical masks, directed staff to ensure that masks were worn in non-clinical areas of the organization including hallways, elevators and public areas and only to be removed and changed in a safe space following appropriate procedures (i.e. ensure you are two meters away from all other staff, patients and visitors, in the event that a two meter distance cannot be maintained a mask is to be applied immediately).

On an identified date, a staff was seen sitting outside of the elevators on an identified floor without a mask. When an inspector approached the staff, they continued to not wear a mask and towards the end

of the conversation they had put on their mask. The staff acknowledged they should have worn their surgical masks when present in a non-designated area and the mask was placed back on after speaking with the inspector.

There was a low risk of infection transmission when staff did not wear surgical masks appropriately in a non-designated area.

Sources: Observation on an identified date; Universal Mask Policy #UHT0000472 dated September 11, 2022, and interviews with staff.

[741674]

Date Remedy Implemented: April 21, 2023.

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 the use of a resident's fall prevention interventions was followed as specified in the plan of care for a resident.

Rationale and Summary:

During an observation on an identified date, a resident was found without close access to their fall interventions when they were unattended.

The resident's care plan stated the fall interventions were to be in place when the resident is in bed.

Staff acknowledged that care plan was not followed related to resident's fall interventions.

When the staff failed to provide care as set out in the plan of care, there was increased risk of harm to resident.

Sources: Observations on an identified date; resident's care plan; and interview with staff.
[000715]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the resident's plan of care so that different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary:

A Critical Incident (CI) was submitted to the Director related to a resident's fall with injury. On an identified date, resident was found on the floor by a staff member.

Resident had a history of falls in the long term care home (LTCH).

On an identified date, a staff verified that resident was found with fall interventions in place as per resident's care plan.

PT #123 acknowledged resident's fall interventions were contra-indicated. Director of Care #105 acknowledged that different aspects of care provided by the inter-disciplinary staff for resident were not consistent and did not complement each other.

The gap in collaboration between nursing team and physiotherapy in the development and implementation of the plan of care may have contributed to resident's falls.

Sources: Critical Incident; resident's clinical records; interviews with staff.

[741674]

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 the care set out in the plan of care for resident related to provision of continence care and resident's preference for staff were provided.

Rationale and Summary:

A CI was submitted to the Director related to an alleged staff to resident physical abuse. Resident

reported to their family that their injury was caused by a staff.

(a) Resident's care plan indicated they required a certain level of assistance.

Upon review of the resident's clinical records, it was identified that the staff provided a certain level of assistance to the resident, which differed from their care plan.

Staff acknowledged that on an identified date resident's care plan was not followed when care was provided to resident.

There was increased risk of harm to resident when staff failed to follow the care plan.

Sources: LTCH's investigation notes; resident's clinical records; interview with staff.
[000715]

Rationale and Summary:

(b) Resident's care plan specified preference for care not to be provided by a staff.

The LTCH's investigation noted that certain staff provided care to resident on an identified date and resident was discovered with injury.

A specific staff reported they provided care for resident for a period of time prior to the alleged incident. The Clinical Operations Lead #112 acknowledged resident's care plan was not followed as per their preference.

There was increased risk of harm to resident when staff failed to follow the care plan.

Sources: LTCH's investigation notes; resident's clinical records; interview with staff and Clinical Operations Lead #112.
[000715]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure a staff member who had reasonable grounds to suspect abuse of a

resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary:

The LTCH submitted a CI for an alleged abuse incident and this was reported to the Director two days after the incident. The home initiated an investigation into the incident a day before reporting to the Director.

The Clinical Operations Lead #112 acknowledged that an investigation was initiated the same day, however failed to report the incident to the MLTC.

Sources: Critical Incident Report; resident's progress notes; and interview with Clinical Operations Lead #112.
[000715]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure, when a resident had fallen, they were assessed and that a post-fall assessment was conducted.

Rationale and Summary:

The home's policy indicated registered staff were to complete a post fall assessment in Point Click Care to identify factors that may have caused the fall and to add or change interventions appropriately.

On an identified date resident experienced a fall and a post fall assessment was not completed.

Clinical Operations Lead #130 acknowledged that the LTCH policy was not followed.

Failure to complete a post fall assessment increased the risk that a resident would continue to fall without implementing appropriate interventions.

Sources: Falls Prevention and Management policy #HP045 (approval date: August 2012); resident's admission assessment and initial care plan; interview with staff.

[741674]

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 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to IPAC was implemented. Specifically, additional requirement 9.1 (f) of the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard) which directs homes to ensure proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

A staff did not follow additional precautions for PPE use when caring for a resident.

Rationale and Summary:

A resident was placed on additional precautions on an identified date.

The resident's door had a sign with additional precautions and a staff was observed exiting the resident's room without additional precautions.

The home's policy directed staff to wear additional precautions when entering a resident's room with additional precaution signage.

Staff acknowledged that they did not follow additional precautions when providing care to resident.

There was an increased risk of infection transmission when staff did not wear appropriate PPE.

Sources: Infection Prevention and Control - Routine Practice and Additional Precautions Policy (18-11 reviewed April 2019); observations on an identified date; and interviews with staff.

[741674]