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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 3, 2023	
Inspection Number: 2023-1503-0005	
Inspection Type: Critical Incident System	
Licensee: Unity Health Toronto	
Long Term Care Home and City: Providence Healthcare, Scarborough	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature** Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2023.08.04 07:53:14 -04'00'
Additional Inspector(s) Arther Chandramohan (000720) Nora Aser (was present during the inspection)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 25-28, and 31, 2023

The following intake(s) were inspected:

- Intake: #00003752 - [Critical Incident (CI): 3006-000026-22] – related to improper/incompetent treatment
- Intake: #00086065 – [CI: 3006-000009-23] – related to a fall with injury
- Intake: #00087979 – [CI: 3006-000011-23] – related to alleged emotional and verbal abuse
- Intake: #00091348 – [CI: 3006-000019-23] – related to alleged sexual and physical abuse

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PROHIBITED DEVICES THAT LIMIT MOVEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 7.

The licensee has failed to ensure that devices such as sheets and gowns were not used for a resident other than for its therapeutic purposes.

Rationale and Summary:
A resident was found on restraints by a staff using a flat sheet and a gown. The resident had no restraints included in their plan of care.

Staff stated the home had zero restraint policy and the resident was not to be restrained.

There was an increased risk for injury to a resident when they were placed on restraints.

Sources: A resident's clinical records, home's investigation notes and staff interviews.

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WRITTEN NOTIFICATION: RESIDENT'S BILL OF RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

The licensee has failed to ensure that the resident's right to refuse or consent for treatment was respected.

Rationale and Summary:
A resident was known for refusing care or treatment as indicated in their plan of care.

The home received a complaint regarding an alleged staff to resident abuse. The complaint indicated that despite the resident's refusal for care, the alleged staff insisted to provide care. The home initiated an investigation, and the resident was reassigned to a different staff.

A staff stated that during the family meeting, the complainant stated that as per the resident, the alleged staff insisted on providing care without their consent and would force the resident to continue with the care.

All staff stated that residents had the right to refuse treatment and if they refused care, staff were expected to stop and reapproach the resident.

There was a risk of harm to a resident when their right to consent for care was not respected.

Sources: A resident's clinical records, home's investigation notes and staff interviews.

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2) A resident had a history of refusing care or treatment as indicated in their plan of care.

The home received a complaint of an alleged staff to resident abuse. The home initiated an investigation. The home's investigation notes indicated that the resident used force against the alleged staff to refuse care and the alleged staff proceeded to provide care without the resident's consent.

The alleged staff stated that at the time of incident, the resident required care due to the condition they were in. The alleged staff confirmed that the resident refused care, but they continued to provide care as they deemed it was a priority.

A staff stated that during their investigation, the alleged staff confirmed that the resident refused care and they continued to provide care.

All staff stated that the residents had the right to refuse treatment and if any resident refused care, staff were expected to stop and reapproach the resident.

There was a risk of harm to a resident when their right to consent for care was not respected.

Sources: A resident's clinical records, home's investigation notes and staff interviews.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 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 a resident's plan of care related to falls were provided as specified in the plan.

Rationale and Summary:
A resident's plan of care indicated they were at high risk for falls and included a specified intervention for fall prevention. The resident had a fall, was transferred to the hospital, and returned to the home with a change in condition.

Staff acknowledged that the resident's specific fall intervention was not provided at the time of fall incident.

Failure to provide the resident's written plan of care as specified resulted in injury.

Sources: A resident's clinical records and staff interviews.

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