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: September 1, 2023	
Inspection Number: 2023-1503-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Unity Health Toronto	
Long Term Care Home and City: Providence Healthcare, Scarborough	
Lead Inspector Arther Chandramohan (000720)	**Inspector Digital Signature** Arther Chandramohan Digitally signed by Arther Chandramohan Date: 2023.09.07 11:22:00 -04'00'
Additional Inspector(s) Susan Semeredy (501)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 24, 25, 28, and 29, 2023

The following intake(s) were inspected:

- Intake: #00093615: Complaint related to care and services and dealing with complaints.
- Intake: #00093790: Critical Incident. 3006-000022-23. Related to improper/incompetent care of resident related to skin integrity.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Reporting and Complaints

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 (4) (b)

The licensee has failed to ensure that PSW staff collaborated in the development and implementation of the plan of care for a resident who developed a skin injury.

Rationale and Summary:
A resident developed a new skin injury during different parts of care and the PSWs that were made aware of this did not communicate this to the registered staff to ensure appropriate assessment and treatment.

Management staff confirmed that PSW staff in this scenario failed to communicate and collaborate with the registered staff related to this resident's skin injury.

Failure to communicate and collaborate with the registered staff may have delayed appropriate and timely treatments for the resident's skin injury.

Sources:
Interviews with staff and private sitter. Record review of progress notes, plan of care, and investigation notes by the facility. [000720]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward a complaint to the Director alleging risk of harm to residents.

Rationale and Summary
The home’s complaint binder included a complaint regarding a resident. The complaint implied the resident may have been harmed by inappropriate medication administration in several incidents alleged

in the complaint. The Interim Director of Care (DOC) confirmed there was a risk of harm to the resident and other residents alleged in the complaint, and this should have been reported to the Ministry of Long-Term Care.

Failing to report matters to the Director puts residents at further risk of harm.

Sources: The home's complaint binder and an interview with the Interim DOC. [501]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 107

The licensee has failed to ensure that the written procedures for reporting and complaints incorporated the requirements set out in the Regulation.

Rationale and Summary
The home's policy did not specify that a response to a person who made a complaint should include:

- The Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010, and
- If the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The Interim DOC confirmed the home's policy had not been revised to reflect the Fixing Long-Term Care Act, 2021 (FLTCA) and Ontario Regulation 246/22.

Sources:

The home's policy titled "Complaint Management" last revised September 9, 2021, and an interview with the Interim DOC. [501]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee failed to include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010 when responding to persons who made complaints.

Rationale and Summary

The home's complaint binder included a number of complaints made in 2023. Documentation of these complaints did not indicate the home included the above information in their response to the complainants. The Interim DOC confirmed that this was something the home had not been undertaking.

Sources:

The home's 2023 complaint binder and an interview with the interim DOC. [501]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary

Within the home's 2023 complaint was a written complaint regarding a resident. There was no documentation that any response was provided to the complainant. The Interim DOC confirmed that the documentation was not included.

Sources:

The home's 2023 complaint binder and an interview with the Interim DOC. [501]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in an area that was secured and locked.

Rationale and Summary

Several prescription creams were found in the resident's room. The treatment administration record (TAR) and RPN #113 indicated that these creams were previously prescribed for the resident and should

have been destroyed. The interim DOC confirmed that prescription creams should not be left in the resident's room.

Failing to keep prescribed creams secured and locked put residents at risk for harm.

Sources:

Observation, review of resident TAR, and interviews with RPN and Interim DOC. [501]