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

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Public Report

Report Issue Date: April 1, 2025
Inspection Number: 2025-1503-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Unity Health Toronto
Long Term Care Home and City: Providence Healthcare, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 20, 21, 24, 25, 26, 27, 28, 31, 2025 and April 1, 2025

The following intake was inspected:

- Intake: #00142741 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised, when the resident's care needs changed. The resident required a specified sized equipment for their transfer but was observed with a different size of equipment.

The resident's plan of care was revised to update the correct size of equipment for the resident's transfer after the inspector's observation.

Sources: Observation, resident's clinical records and interviews with a resident, a Personal Support Worker (PSW) and other staff.

Date Remedy Implemented: March 26, 2025
NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 11.6 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that signage was posted throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

On March 21, 2025, the signage was posted.

Sources: Observations; Interview with the Director of Care (DOC) and the IPAC Professional.

Date Remedy Implemented: March 21, 2025
NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

The licensee has failed to ensure that the 2024 continuous quality improvement

(CQI) report contained the results of the home's annual Resident and Family/Caregiver Experience Survey. The Quality Improvement Specialist and Lead confirmed that the home's report did not contain information pertaining to the results of the home's annual survey for 2024.

A revised CQI report was reviewed on March 31, 2025, and contained this requirement.

Sources: CQI report for 2024; Interview with the Quality Improvement Specialist and Lead.

Date Remedy Implemented: March 31, 2025
NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the 2024 CQI report contained information on how the results of the annual survey were communicated with the residents and their families, Residents' Council and Family Council along with the staff members of the home. The Quality Improvement Specialist and Lead confirmed that the home's report did not contain this information in the 2024 CQI report.

A revised CQI report was reviewed on March 31, 2025, and contained this requirement.

Sources: CQI report for 2024; Interview with the Quality Improvement Specialist and Lead.

Date Remedy Implemented: March 31, 2025
NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the 2024 CQI report contained information on how actions undertaken to improve the long-term care home were communicated with the residents and their families, resident and family council along with the staff members of the home. The Quality Improvement Specialist and Lead confirmed that the home's report did not contain this information in the 2024 CQI report.

A revised CQI report was reviewed on March 31, 2025, and contained this requirement.

Sources: CQI report for 2024; Interview with the Quality Improvement Specialist and Lead.

Date Remedy Implemented: March 31, 2025
NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-

term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure the current version of the visitor policy was posted in the home. On March 20, 2025, during the initial tour of the home, the inspector observed the visitor policy was not posted in the home.

The visitor policy was posted in the home later the day on March 20, 2025.

Sources: Observations and interview with the DOC.

Date Remedy Implemented: March 20, 2025

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas were kept locked when unsupervised. On March 20, 2025, the doors to the soiled utility rooms and spa rooms, which residents did not have unsupervised access to, were observed to be unlocked on several units in the home.

Sources: Observation and interview with the DOC.

WRITTEN NOTIFICATION: Windows

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that windows in the resident rooms could not be opened more than 15 centimetres (cm). During an initial tour of the home on March 20, 2025, the windows in two residents' rooms were observed could be opened more than 15cm.

Sources: Observation and interview with the DOC.

WRITTEN NOTIFICATION: Air temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The licensee has failed to ensure that the temperature was measured and documented in writing, in one resident common area on every floor of the home. There were no records of measurements in resident common areas of the second,

third and fourth floors of the home in the last week of March 2025.

Sources: Home's air temperature records and interview with Environmental Services Manager and the DOC.

WRITTEN NOTIFICATION: Air temperature

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)
Air temperature
s. 24 (5) The licensee shall keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

The licensee has failed to ensure to keep a record of the measurements documented for the air temperatures of different areas of the home for at least one year. There were no records of temperature measurements from September 2, 2024 to February 28, 2025.

Sources: Home's air temperature records and interview with the Manager of Environmental Services and the DOC.

WRITTEN NOTIFICATION: General requirements

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance

with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the pain management program was evaluated and updated annually. The DOC confirmed that the home had not completed the pain management program evaluation for 2024.

Sources: Interview with the DOC; Review of email exchanges from the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure a resident was assessed by the Registered Dietitian (RD) when an area of altered skin integrity had worsened. The RD confirmed that they should have received a referral from the nursing staff when the resident's altered skin integrity worsened so that an assessment could be conducted and changes to the resident's nutrition interventions could be implemented.

Sources: Review of a resident's progress notes and care plan; Home's policy titled; Houses of Providence- Skin Care and Pressure Injury Prevention, dated July 2021;

Interview with the RD and a Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Menu planning

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the written record for the Fall/Winter 2024/2025 menu cycle evaluation contained the date of the evaluation, the names of the persons who participated in the evaluation and the dates the changes were implemented. The RD confirmed that the menu evaluation that was conducted for the Fall/Winter 2024/2025 cycle was not kept in a written format which included the date of the evaluation, the names of the persons who participated in the evaluation and the dates that the changes were implemented.

Sources: Review of the home's menu evaluation; Email communication with the RD.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was implemented.

i). In accordance with Additional Requirement 4.3 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that following the resolution of the outbreak that occurred in January 2025, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak.

Sources: CIS report #3006-000003-25; Interview with the DOC and the IPAC Professional.

ii). In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that a Lead Hand demonstrated proper use of personal protective equipment (PPE), when they were seen wearing the same gloves to pick up multiple sharp containers on a resident unit.

Sources: Observations; Interview with the Lead Hand and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and

Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that two Lead Hands participated in the implementation of the home's IPAC program, as it related to the application of surgical masks on resident units under an outbreak. Two Lead Hands were observed to be not wearing a surgical mask while they were in resident units that were in an outbreak. The DOC stated that surgical masks were required on units that were in outbreak.

Sources: Observations; Interview with two Lead Hands and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's symptoms were recorded on each shift when they were diagnosed with a respiratory infection. A review of the documentation indicated that the resident's assessments and/or symptoms were not documented for three shifts, while the resident was actively exhibiting symptoms and on isolation precautions.

Sources: Review of resident's assessments and progress notes from PointClickCare (PCC); Interview with the DOC and the IPAC Professional.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that an interdisciplinary team that included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The home's last quarterly evaluation of the medication management system on January 16, 2025, indicated that the Medical Director was not present for the evaluation.

Sources: The home's quarterly evaluation of the medication management system and interview with the DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (b)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,

(b) any changes and improvements identified in the review are implemented; and

The licensee has failed to ensure that changes and recommendations were identified in the quarterly review of medication incidents and adverse drug reactions. In the home's last quarterly review of medication incidents and adverse drug reactions conducted on January 16, 2025, changes and recommendations were not identified in the review.

Sources: Home's last quarterly review of medication management system and medication incidents and interview with DOC.

WRITTEN NOTIFICATION: Orientation

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that all staff in the home were trained on the IPAC topic of handling and disposing of biological and clinical waste including used PPE. The IPAC Professional was unable to demonstrate that this topic was included in their annual IPAC training for staff.

Sources: Review of the home's IPAC training modules located on Surge Learning; Email exchanges with the IPAC Professional; Interview with the DOC.