Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2020	2020_784762_0021	021743-19, 021744-19, 021745-19, 002367-20, 006818-20, 007463-20, 008600-20, 008972-20, 009556-20, 014170-20, 020132-20, 020450-20	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

Long-Term Care Home/Foyer de soins de longue durée

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 20-22, 26-30, November 2-4, 2020

The following Critical Incident Report (CIR) intakes were inspected upon during this Critical Incident System (CIS) Inspection:
Log related to a Compliance Order (CO) #001 in relation to nutrition and hydration
Log related to a Compliance Order (CO) #002 in relation to resident to resident abuse
Log related to a Compliance Order (CO) #003 in relation to medication management

Log related to an unsafe transfer of a resident causing an injury that required a transfer to the hospital
Log related to abuse of a resident causing an injury that required a transfer to the hospital
Log related to a fall causing an injury that required a transfer to the hospital
Log related to a fall causing an injury that required a transfer to the hospital
Log related to a fall causing an injury that required a transfer to the hospital

The following intakes were completed in the Critical Incident System Inspection:

Logs related to falls causing an injuries that required a transfers to the hospital

During the course of the inspection, the inspector(s) spoke with Director of Nursing (DON), BSO Registered Practical Nurses (BSORPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 114. (1)	CO #003	2019_714673_0007	762
O.Reg 79/10 s. 8. (1)	CO #001	2019_714673_0007	762

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

The licensee has failed to protect resident #012 from abuse by resident #008.

Resident #012 had two inappropriate interactions with resident #008 and one with resident #011. None of the residents were capable of consenting to these interactions. A post assessment after the first incident determined that both residents did not show resistance or objection and did not appear to be in distress. The second interaction occurred in June 2020, and the substitute decision maker (SDM) of resident #008 indicated that the resident would not have consented to this interaction. The third interaction that occurred was between resident #012 and resident #011, this interaction was witnessed by a co-resident, however, the interaction was not confirmed and neither resident was in distress. As a result, interaction #1 and #3 were not seen as abuse due to the homes policy which indicated a resident's ability to consent may be demonstrated by a lack of resistance or objection, and by willing participation. As a result, the registered staff did not consider #1 and #3 a non-consensual interaction, however, had considered #2 abuse, due to the comment made by the SDM of resident #008. The licensee did not protect resident #012, who is cognitively impaired and unable to consent to these interactions, from abuse by resident #008. As a result, there was a risk of abuse by resident #008 towards resident #012, as consent could not be clearly determined.

Sources: Residents #008, #011 and #012's progress notes and resident assessment instrument minimum data set (RAIMDS); interview with RN #118; Interviews with BSORPN #122 and #123; Policy published 01-01-2019 and policy no: RC-0308-00.

The licensee has failed to protect resident #010 from abuse by resident #011.

In the month of July, 2020, an injury was caused when resident #011 had wandered into resident #010's room. A review of camera footage by DON #100 indicated that resident #010 was hit by resident #011 that caused an injury, for which resident #010 required an intervention from the hospital. It was noted that resident #010 had responsive behaviors and had attempted to remove resident #011 out of their room, which lead to the altercation. As a result, abuse had occurred due to actual harm caused by resident #011 towards resident #010.

Source: Resident #010's care plan; CIS #M571-000030-20/ M571-000031-20; Interview with DON #100 Compliance Order (CO) #002 related to LTCHA, s.19(1) from inspection 2019_714673_0007 issued on November 12, 2019, with a compliance due date of February 28, 2020, is being re-issued.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The license has failed to ensure that two staff members used safe transfer techniques when transferring resident #006 using a mechanical lift.

Two PSW's attempted to lift resident #006 using a mechanical lift. While doing so, the sling was improperly applied. As a result, the resident started slipping out of the sling, PSW #119 attempted to lower the resident to the ground, as they did this, resident fell out of the sling and was injured, for which the resident had to be taken to the hospital. PSW #119 indicated that this was not a safe transferring technique, as required by their training. As a result, there was harm caused to the resident, as a result of unsafe transferring practices.

Sources: Resident #006's Progress notes; and Interview with PSW #121 [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents,, to be implemented voluntarily.

Issued on this 24th day of November, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2020_784762_0021
Log No. / No de registre :	021743-19, 021744-19, 021745-19, 002367-20, 006818-20, 007463-20, 008600-20, 008972-20, 009556-20, 014170-20, 020132-20, 020450-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 16, 2020
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Seven Oaks 9 Neilson Road, SCARBOROUGH, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Puiatti

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_714673_0007, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must comply with s.19 of the LTCHA
Specifically, the licensee must ensure:
- Resident #010 is protected from physical abuse by resident #011
- Resident #012 is protected from sexual abuse by resident #008
- Interventions are created, and are implemented to prevent resident #011 from entering resident #010's room.

Grounds / Motifs :

1. The licensee has failed to protect resident #012 from abuse by resident #008.

Resident #012 had two inappropriate interactions with resident #008 and one with resident #011. None of the residents were capable of consenting to these interactions. A post assessment after the first incident determined that both residents did not show resistance or objection and did not appear to be in distress. The second interaction occurred in June 2020, and the substitute decision maker (SDM) of resident #008 indicated that the resident would not have consented to this interaction. The third interaction that occurred was between resident #012 and resident #011, this interaction was witnessed by a co-resident, however, the interaction was not confirmed and neither resident was in distress. As a result, interaction #1 and #3 were not seen as abuse due to the homes policy which indicated a resident's ability to consent may be demonstrated by a lack of resistance or objection, and by willing participation. As a result, the registered staff did not consider #1 and #3 a non-consensual interaction, however, had considered #2 abuse, due to the comment made by the SDM of resident #008. The licensee did not protect resident #012, who is cognitively impaired and unable to consent to these interactions, from abuse by resident #008. As a result, there was a risk of abuse by resident #008 towards

resident #012, as consent could not be clearly determined.

Sources: Residents #008, #011 and #012's progress notes and resident assessment instrument minimum data set (RAIMDS); interview with RN #118; Interviews with BSORPN #122 and #123; Policy published 01-01-2019 and policy no: RC-0308-00. (762)

2. The licensee has failed to protect resident #010 from abuse by resident #011.

In the month of July, 2020, an injury was caused when resident #011 had wandered into resident #010's room. A review of camera footage by DON #100 indicated that resident #010 was hit by resident #011 that caused an injury, for which resident #010 required an intervention from the hospital. It was noted that resident #010 had responsive behaviors and had attempted to remove resident #011 out of their room, which lead to the altercation. As a result, abuse had occurred due to actual harm caused by resident #011 towards resident #010.

Source: Resident #010's care plan; CIS #M571-000030-20/ M571-000031-20; Interview with DON #100Compliance Order (CO) #002 related to LTCHA, s.19(1) from inspection 2019_714673_0007 issued on November 12, 2019, with a compliance due date of February 28, 2020, is being re-issued as follows:

Severity: Resident #010 sustained an actual injury due to resident #011's responsive behavior. This injury required intervention from the hospitaland caused a significant change as per the definition in the act.
Scope: This non-compliance was a pattern as two out of the five residents reviewed had been abused.
Compliance History: Compliance Order #002 is being re-issued for the licensee failing to comply with s.19(1) of the LTCHA. This subsection was issued as a CO on November 12, 2019, during inspection #2019_714673_0007 with a compliance due date of February 28, 2020. In the past 36 months, seven other COs were issued to different sections of the legislation, six of which have been complied and one rescinded. (762)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 25, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Moses Neelam

Service Area Office /
Bureau régional de services : Central East Service Area Office