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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2022	2022_984469_0003	017059-21	Complaint

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

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

AMA AGYEMANG (722469)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 15 - 18, 21 - 24, 2022

An Infection Prevention and Control Inspection was completed concurrent to this Complaint Inspection

The following intakes were completed during this Complaint Inspection:

One intake related to a complaint regarding the infection prevention and control practices and personal protective equipment in the home
One intake related to declared COVID-19 outbreak in the home.

During the course of the inspection, the inspector(s) spoke with Infection Prevention and Control Lead, Infection Prevention and Control Practitioner, Registered Practical Nurse (RPN), Personal Support Worker (PSW)

During the course of the inspection, The inspector observed residents, home areas, staff to resident interactions, relevant home policies and procedures, and other relevant documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

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

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1.The licensee failed to comply with Ontario Regulation 79/10, s. 229(4) was found.

Ontario Regulation 79/10, s. 229(4) states that staff participation is required for the implementation of the infection prevention and control program.

On one occasion, RPN #108 was noted removing the garbage from the medication cart while wearing gloves. After removing the garbage, RPN #108 proceeded to remove napkins from around the neck of four residents. RPN #108 did not complete the four moments of hand hygiene as per best practice and indicated on the signage posted on the walls in the home.

On another occasion, staff were observed not following the elevator capacity requirement. Signage in the home's elevators indicate a maximum capacity of three passengers. During this occasion the elevator was noted to have four occupants at the same time. In follow-up with one of the staff in the elevator they acknowledged being aware of the capacity limit but indicated the second elevator was not working properly. The risk involved in these instances is that both actions increase the risk of transmitting infection which could then spread throughout the home.

SOURCES
Interview with RPN #110 and PSW #109, infection control signage, Infection Control policy. [s. 229. (4)]

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 and the licensee shall ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 5th day of April, 2022

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

Original report signed by the inspector.