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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 6, 2023	
Original Report Issue Date: May 24, 2023	
Inspection Number: 2023-1580-0003 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Seven Oaks, Scarborough	
Amended By Fiona Wong (740849)	**Inspector who Amended Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.06.09 13:49:43 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the licensee's request for a compliance due date extension. The inspection #2023_1580_0003 was completed on April 25, 2023.

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Amended Public Report (A1)

Amended Report Issue Date: June 6, 2023	
Original Report Issue Date: June 9, 2023	
Inspection Number: 2023-1580-0003 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Seven Oaks, Scarborough	
Lead Inspector Fiona Wong (740849)	**Additional Inspector(s)** Ann McGregor (000704)
Amended By Fiona Wong (740849)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the licensee's request for a compliance due date extension. The inspection #2023_1580_0003 was completed on April 25, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11-14, 17-20, 24-25, 2023

The following intake(s) were inspected:

- Intake: #00017448 - M571-000001-23 - related to responsive behaviours.
- Intake: #00018591 - complaint related to continence care and bowel management.
- Intake: #00020677 - Follow-up #: 2 - related to plan of care.
- Intake: #00084269 - complaint related to nutrition and hydration program and plan of care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1580-0002 related to FLTCA, 2021, s. 6 (7) inspected by Fiona Wong (740849)

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in a resident's nutritional care collaborated with each other in the development and implementation of the plan of care so that the care was integrated and were consistent with and complement each other.

Rationale and Summary
The resident was identified to be at nutritional risk.

In a specified month, a Registered Dietitian (RD) #124 recommended a diet change and various dietary interventions to improve the resident's nutritional risk.

In reviewing Point of Care (POC) documentation by Personal Support Workers (PSWs), the dietary interventions were frequently refused since they were initiated. Progress notes by a Registered Practical Nurse (RPN) also noted refusals or poor intake of dietary interventions. A PSW, the RPN, and RD #116

stated that the goal to increase the resident's intake was not met when the dietary interventions were frequently refused, and the resident's nutritional risk did not improve. No action was taken by nursing staff to address the resident's refusal to RD #124's interventions and their nutritional risk.

RD #124 eventually followed up with the resident, when the resident expressed dislike for the dietary interventions.

The home's Nutrition and Hydration Policy (RC-0523-27) states that part of care planning and evaluation is for nursing staff, RD, and the nutrition manager to monitor the effectiveness of the plan of care interventions, and/or initiate new referrals to the physician or the RD, according to resident and family goals and preferences.

The Director of Care (DOC) stated nursing staff were expected to find out and understand why the resident was frequently refusing the provided interventions and refer to the RD. RD #116 indicated it was the RD's job to follow up on the effectiveness of interventions, however, the nursing staff could have identified the effectiveness of the interventions earlier, and notify RD as needed.

Failure of the interdisciplinary team to collaborate and monitor the effectiveness of the resident's plan of care interventions resulted in delaying the process of addressing their nutritional needs.

Sources: the resident's clinical records, the home's Nutrition and Hydration policy, interviews with a PSW, an RPN, RD #116, and the DOC.

[740849]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to comply with the strategies to manage a resident's responsive behaviours.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there are resident monitoring and internal reporting protocols as well as protocols for the referral of residents to specialized resources for residents who demonstrates responsive behaviours.

Specifically, staff did not comply with the policy "Responsive Behaviours Management".

Rationale and Summary
The home's policy on Responsive Behaviours Management indicates that staff should complete a Dementia Observation System (DOS) tool and initiate a behavioural support referral when a resident exhibits new or worsening behaviour. The tool is required to be completed or initiated by any registered staff or PSW. The referral is completed by any registered staff. The completion of these tools would then be analyzed by the Behavioural Support Ontario (BSO) team for further assessments, treatments, and referrals.

The resident exhibited responsive behaviours towards co-residents and staff. On a number of specified dates, there were responsive behaviours exhibited by the resident which did not result in the completion of the DOS tool or referrals being sent to the BSO team. A week after the specified dates, BSO acknowledged that the resident's behaviour worsened. A PSW, an RN and a Nurse Manager confirmed that on the specified dates, DOS monitoring and BSO referral should have been completed.

There was risk to the resident as their worsening responsive behaviour was not identified and addressed in a timely manner when DOS monitoring and BSO referral was not completed.

Sources: CIS #M571-000001-23, the home's Behavioural Response – Care Strategies policy, Behavioural Assessment tool – Modified Dementia Observation System policy, the resident's clinical records, interviews with a PSW, an RN, the BSO Lead and a Nurse Manager.

[000704]

WRITTEN NOTIFICATION: Emergency Plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 230 (4) 1. v.

The licensee has failed to comply with the plan to manage a resident's medical emergency.

In accordance with O. Reg. 79/10, s. 8 (1) (b), the licensee is required to ensure that their emergency plan provided for dealing with medical emergencies and must be complied with.

Specifically, staff did not comply with the policy "Code Blue Procedure During COVID-19 Pandemic".

Rationale and Summary

On a specified date, an RPN was notified by a PSW that the resident was not feeling well. The RPN found the resident in their room with specified symptoms. The RPN left the resident's room, when they found the resident in this condition and went to the nursing station to call 911 and asked another RPN to check the resident's vitals.

The home's Code Blue procedure policy states that the first registered nursing staff arriving on the scene becomes the lead. The lead registered staff will assess for respiratory effort by visual inspection and check pulse by assessing a femoral or brachial pulse. The lead registered staff will notify second responder to call 911.

The DOC indicated that the first nurse at the scene should have been the lead and it was not appropriate for the lead nurse to leave the resident to call 911.

Failure to follow the home's policy increased the risk of not attending to the resident in a timely manner during a medical emergency.

Sources: the resident's clinical records, the home's Code Blue Procedure during COVID-19 Pandemic, interviews with a PSW, two RPNs, and the DOC.

[740849]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there were clear directions provided for staff and others in the plan of care for a resident.

Rationale and Summary
The resident had a history of responsive behaviours. On a specified date, an altercation between the resident and a co-resident resulted in harm. In the resident's care plan, there were two interventions that were contradicting. A PSW, a Registered Nurse (RN), and a Nurse Manager agreed that the directions that were being provided to staff were not clear.

There was risk as staff might not know how to intervene when the resident demonstrated responsive behaviours toward others.

Sources: Interviews with a PSW, an RN, and a Nurse Manager. Behavioural Response – Care Strategies policy, and the resident's plan of care.

[000704]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Educate a specified PSW on the home's process of documenting residents' activities of daily living (ADLs).
2) Document the education from step 1, including the date and the staff member who provided the education.
3) Conduct an audit for a period of two weeks covering all shifts to ensure their ADL records for three random residents are accurately documented. Analyze the results of the audits and ensure corrective actions are taken.
4) Conduct an audit for a period of two weeks to ensure the appropriate intervention was followed for three random residents who have a history of a medical condition. Analyze the results of the audits and ensure corrective actions are taken.
5) Identify or develop interventions to manage a specified resident's wandering behaviour.
6) Conduct an audit for a period of two weeks to assess the effectiveness of the interventions identified in step 5.
7) Maintain a documented record of the audits conducted in steps 3, 4, and 6, to include, but not limited to: dates of audit completion, residents audited, results of each audit and corrective actions taken in response to the audits.

Grounds
The Licensee has failed to protect resident #005 from physical abuse by resident #004.

Rationale and Summary
Resident #004 had a history of responsive behaviours. On a specified date, an altercation ensued between resident #004 and resident #005 causing harm to resident #005. Resident #005 was taken to the hospital with an injury sustained. An RN, the BSO Lead and a Nurse Manager confirmed that there was physical abuse to resident #005 and acknowledged that there was harm to resident #005 due to the responsive behavior of resident #004.

As a result of this incident, there was moderate impact to resident #005's health status, as they were injured from resident #004's responsive behaviours.

Sources: Resident health records, Critical Incident Systems (CIS) Report, and staff interviews.

[000704]

The licensee has failed to protect a resident from neglect by the licensee or staff.

Rationale and Summary
On a specified date, the resident complained of a medical problem. An intervention was initiated. An RPN followed up and documented to be ineffective.

The RPN and the DOC stated that further actions were not taken when it was followed up and documented to be ineffective.

There was no documentation to support that staff followed up with the resident to see if their medical problem was resolved.

The resident was seen in routine weekly rounds by the Medical Doctor (MD) within the time frame of when they were experiencing their symptoms, however the medical problem was not addressed during that visit. There was no documentation to support that the resident was referred to the MD related to their medical concern.

The resident's medical condition was also inaccurately documented in their POC records, which was confirmed by the DOC. The resident had to express their medical concern to the staff because they did not identify it in the resident's POC records.

The home's policy indicates that staff are to monitor and review accurately related to a resident's ADLs, and to ensure proper actions are taken to address any potential medical concerns that arise.

Without accurate documentation of the resident's ADLs and active follow ups of the resident's identified medical concern, the resident's medical condition was left unaddressed.

The resident was sent to the hospital and had a significant change in their condition after their condition worsened. They were diagnosed with a severe condition that aroused from the complaint of their medical condition.

Failure to follow up with the resident's medical concern contributed to actual harm to the resident.

Sources: the resident's clinical records, two of the home's policies, interviews with two PSWs, an RPN, the RAI Coordinator, and the DOC.

[740849]

This order must be complied with by August 11, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

LTCHA, 2007, s 19 (1) and FLTCA, 2021, s. 24 (1)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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