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 7, 2023

Inspection Number: 2023-1580-0004

Inspection Type:
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Seven Oaks, Scarborough

Lead Inspector	**Inspector Digital Signature**
Fiona Wong (740849)	Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.09.07 16:26:05 -04'00'

Additional Inspector(s)
Cindy Cao (000757)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, 2023 and September 1, 2023.

The following intake(s) were inspected:

- Intake: #00086369 - Critical Incident (CI): M571-000018-23 - related to injury of unknown cause.
- Intake: #00088617 - follow up intake related to duty to protect.
- Intake: #00089976 - CI: M571-000025-23 - related to falls prevention and management.

The following intake(s) were completed:

- Intake: #00086653 - CI: M571-000019-23, Intake: #00087422 - CI: M571-000021-23, and Intake: #00089445 - CI: M571-000024-23 - related to falls prevention and management.
- Intake: #00090915 - CI: M571-000026-23 - related to injury of unknown cause.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1580-0003 related to FLTCA, 2021, s. 24 (1) inspected by Fiona Wong (740849)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure two residents were assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the residents exhibited altered skin integrity.

(i) Rationale and Summary
The home's skin care and wound prevention management policy directs staff to conduct an assessment when a resident exhibits altered skin integrity. Interview with the Nurse Manager/Skin Care Coordinator confirmed that a skin and wound assessment tool was to be completed when conducting initial and ongoing wound assessments.

A resident exhibited altered skin integrity following an incident. The resident's clinical records indicated that the skin and wound assessment was started by a Registered Practical Nurse (RPN), however the assessment was not completed.

Sources: Resident's progress notes and assessment records; interviews with an RPN and a Nurse Manager/Skin Care Coordinator and the home's "Skin Care and Wound Prevention and Management" policy.

[000757]

(ii) Rationale and Summary

A resident sustained altered skin integrities on two different occasions.

The resident's clinical records indicated that the skin and wound assessment was not completed after the resident sustained altered skin integrities.

Three RPNs and the Director of Care (DOC) indicated that the skin and wound assessment tool should have been completed.

Failure to complete a skin and wound assessment when the residents exhibited altered skin integrity delayed the identification and treatment to manage the residents' skin conditions.

Sources: The resident's clinical records, interviews with three RPNs and the DOC, the home's "Skin Care and Wound Prevention and Management" policy.

[740849]