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: February 14, 2024
Original Report Issue Date: December 22, 2023
Inspection Number: 2023-1580-0006 (A1)
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Seven Oaks, Scarborough

Amended By Ann McGregor (000704)	**Inspector who Amended Digital Signature** Ann McGregor Digitally signed by Ann McGregor Date: 2024.02.14 15:15:21 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The Licensee Inspection Report has been revised to reflect the results of a Director Review (DREV) #182, based on the decision of the Director, Noncompliance (NC) #003 and Compliance Order (CO) #001 are rescinded. Administrative Monetary Penalty (AMP) #001 issued with CO #001 is also rescinded.

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Licensee: City of Toronto	
Long Term Care Home and City: Seven Oaks, Scarborough	
Lead Inspector Ann McGregor (000704)	**Additional Inspector(s)**
Amended By Ann McGregor (000704)	**Inspector who Amended Digital Signature** Ann McGregor Digitally signed by Ann McGregor Date: 2024.02.14 15:07:02 -05'00'

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INSPECTION SUMMARY

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Long-Term Care Operations Division
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Toronto District
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Telephone: (866) 311-8002

The inspection occurred onsite on the following date(s): November 27 - 30, 2023 and December 1, 2023
The inspection occurred offsite on the following date(s): December 11, 2023

The following intake(s) were inspected on the Critical Incident (CI) inspection.

- Intake: #00100142 - (CI: M571-000034-23) - COVID-19 outbreak
- Intake: #00100591 - (CI: M571-000035-23) - Fall of resident resulting in injury.

The following intake was completed in this Critical Incident inspection.

- Intake: #00101775 - (CI: M571-000038-23) - Fall of resident resulting in injury.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care
NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care

Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different

aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident, collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rational and Summary
A resident was identified at high risk for injury and the initial assessment indicated that the resident had a safety risk during ambulation.

The resident requested the assistance for ambulation

The Physiotherapist (PT) did not receive the referral for the resident and there were no changes made to the initial admission assessment plans.

The nursing rehabilitation program initiated a preventative plan for resident but the physiotherapy team was not aware of the plan and did not integrate a program for the resident.

The Registered Nurse (RN) acknowledged that resident was unsteady since admission and did not communicate this information to the multidisciplinary team.

The Doctor, PT, and Director of Nursing (DON) acknowledges that the lack of communication resulted in furthering the resident's risk of injury.

There was a moderate risk to the resident when the care team did not collaborate with each other in the development and implementation of preventative measures and programs.

Sources: Resident's Clinical Records, interviews: RN, Doctor, PT, DON and others. [000704]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 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 all staff participated in the implementation of their Infection Prevention and Control (IPAC) program.

Rational and Summary
i) On a day, the inspector observed a Personal Support Worker (PSW) in the common area with residents and did not have a mask on. The PSW remained without a mask for some time until they were confronted by a nurse on the unit to put a mask on.

In an interview with the PSW confirmed that they are aware of the masking policy of the home and the requirement of all staff to comply. The PSW confirmed that there was a risk to other residents when masking policy is not followed.

ii) On another day, the inspector observed a Registered Practical Nurse (RPN)

pouring med pass at the medication cart in the resident's common area. The RPN did not have their mask properly fitted. In an interview with the RPN, they acknowledged that they are aware that there is a policy in place for masking requirements in the home and the importance of following them.

iii) On another day, the inspector observed an RPN assisting a resident in the common area with their gloves on and their mask improperly fitted. The RPN confirmed that they are aware of the requirements of the IPAC practices in the home and the importance of following them.

IV) On another day, the inspector observed food in the nursing station. In an interview with the RN, they confirmed that food in the nursing station goes against the IPAC practice of the home. The RN did remove the food.

The IPAC Practitioner and IPAC manager confirmed that staff did not follow the home's IPAC policies and practices.

There were significant risk to residents when staff did not follow the home's IPAC policies and practices.

Sources: Inspector 000704's observation; interviews with IPAC Practitioner, IPAC manager, PSW, RPN, RN and others.
[000704]

(A1) Appeal/DREV #: DREV #182
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

REVIEW/APPEAL INFORMATION

TAKE NOTE 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

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.