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: April 8, 2024
Original Report Issue Date: March 22, 2024
Inspection Number: 2024-1580-0001 (A1)
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Seven Oaks, Scarborough

Amended By Dorothy Afriyie (000709)	**Inspector who Amended Digital Signature** Dorothy A Afriyie Digitally signed by Dorothy A Afriyie Date: 2024.04.09 15:02:14 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct date of disease outbreak in NC #005, amend the Compliance Due Date for CO #001, clarify step 3 of CO #001 and correct compliance history information in AMP #001.

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Long Term Care Home and City: Seven Oaks, Scarborough	
Lead Inspector Dorothy Afriyie (000709)	**Additional Inspector(s)** Britney Bartley (732787)
Amended By Dorothy Afriyie (000709)	**Inspector who Amended Digital Signature** Dorothy A Afriyie Digitally signed by Dorothy A Afriyie Date: 2024.04.09 15:02:56 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct date of disease outbreak in NC #005, amend the Compliance Due Date for CO #001, clarify step 3 of CO #001 and correct compliance history information in AMP #001.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 14-16, 20- 23, 26, 29, and March 1, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00103271/CI #M571-000040-23, #00103847/CI #M571-000041-23 – were related to resident to resident physical abuse;
- Intake: #00104285/CI #M571-000042-23, #00105174/CI #M571-000044-23, #00106057/CI #M571-000003-24, Intake: #00107747/CI #M571-000005-24, #00109389/ CI #M571-000009-24- were related to falls prevention and management;
- Intake: #00106515/CI #M571-000004-24 – was related to disease outbreak

The following intake(s) were completed in this complaint inspection

- Intake: #00104112 – was a complaint related to physical abuse and damaged personal items

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident in relation to footwear used for falls prevention.

Rationale and Summary:
Resident #005's plan of care indicated that the resident was to wear well-fitting non-slip shoes to mitigate their risk of falls.

On a specified date, the resident fell and sustained an injury. Personal Support Workers (PSW) indicated at the time of the fall, the resident was not wearing well-fitting non-slip footwear.

A Nurse Manager confirmed that there was a risk of the resident falling if they were not wearing appropriate footwear.

Failure to ensure that resident #005 was wearing appropriate footwear increased their risk for falling and injury.

Source: Resident #005's care plan, interviews with PSW #111, 113, #115 and Nurse Manager #108.
[000709]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure the baseboards in resident #003's room were maintained in a good state of repair.

Rationale and Summary:
On a specified date, housekeeper #103 cleaning the floor in a resident floor in a room. Upon leaving the room, they heard noise from the next room and found a resident on the floor, which was wet.

PSW #101 and Registered Practical Nurse (RPN) #104 indicated resident #003 sustained a fall in their room. The PSW and RPN also indicated the resident informed them they slipped on liquid that was coming from their baseboard.

Both PSW and RPN traced the liquid to be coming from the resident's baseboard and suspected the liquid had seeped through the baseboard from the other room.

Further investigation by the home determined the baseboard of the room was lifted and had small cracks. Environmental Manager #105 confirmed the baseboard of the room was not in a good state of repair and resulted in the liquid seeping into the adjacent room.

Failure to maintain the baseboard in the resident room in a good state of repair posed risk of injury to a resident.

Sources: Resident #003's clinical records, the Long-Term Care home's investigation file, interviews with PSW #101, RPN #104 and the environmental manager #105. [732787]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting residents #004 and #005 with transferring.

Rationale and Summary:
(i) A Critical incident report was submitted related to resident #005's fall that

resulted in an injury.

The home's policy indicated that staff must not manually lift a resident and shall maintain a no lift policy and practice using appropriate assistive devices.

Clinical records indicated that staff manually lifted the resident from the floor after the fall. RPN #116 and PSW #111 also confirmed that the resident was lifted from the floor and no assistive device was used.

Nurse Manager #108 and Physiotherapist #107 confirmed staff should not have lifted the resident from the floor and the expectation was to use an assistive device.

Failure to use safe transferring techniques when assisting resident #005 after a fall, placed the resident at risk for further injury.

Source: The home's policy titled "No Lift Policy # RC-0522-09 dated January 1, 2015, CI #M571-000042-23, resident #005's clinical records, interviews with Nurse Manager #108, RPN #116, PSW #111 and other staff.
[000709]

(ii) On a specified date, a PSW was assisting resident #004 when they had a fall.

Clinical records indicated that staff manually lifted the resident from the floor after the fall. RPN #110 and PSW #122 also confirmed that the resident was lifted from the floor and no assistive device was used.

Nurse Manager #109 and Physiotherapist #107 confirmed staff should not have lifted the resident from the floor and the expectation was to use an assistive device.

Failure to use safe transferring techniques when assisting resident #004 after a fall, placed the resident at risk for further injury.

Source: The home's policy titled "No Lift Policy #RC-0522-09 dated January 1, 2015, resident #004's clinical records, interview with RPN #110, PSW #122, and other staff. [000709]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001 and #002 by identifying and implementing interventions.

Rationale and Summary:
On a specified date, resident #002 wandered into resident #001's bedroom, which led to an altercation in which resident #002 was injured. A device was to be placed

across resident #001's doorway to discourage co-residents from entering.

Video footage showed, at the time of the incident, the device was not placed across the door. Prior to resident #002 entering resident #001's room, a staff had passed by the room and did not implement the device as required.

NM #108 acknowledged it was the responsibility of staff to ensure the device was always placed across resident #001's doorway to discourage co-residents from entering their room.

Failure to implement the intervention of a device across resident #001's doorway, led to an altercation that resulted in injury of resident #002.

Sources: Resident #001's and 002's clinical records, LTCH's video footage, interviews with NM #108 and other staff.
[732787]

WRITTEN NOTIFICATION: REPORT RE CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to ensure that the Director was immediately informed of a

disease outbreak.

Rationale and Summary:
The Infection prevention and control (IPAC) manager #109 was notified by Public Health to declare an outbreak of respiratory syncytialon virus (RSV) on two floors on a specified date. The IPAC manager #109 informed the Director by completing a Critical Incident (CI) report was submitted on the same day after normal business hours. The licensee was required to immediately report the disease outbreak using the Ministry's after-hours emergency line.

The IPAC manager #109 acknowledged they did not call the after hours because they thought that by completing the CI during the after-hours would still be considered as immediate reporting.

There was low risk to the residents when the Director was not informed using the established after-hours method.

Sources: CI report #M571-000004-24 and interview with IPAC manager #109. [732787]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #006 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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Provide education to Registered staff and PSWs on specified resident home areas on the interventions in place to prevent harmful altercations between residents #001 and #006 and co-residents.
2. Maintain a record of all the training provided, including the date, who conducted the training, staff attendance and the contents of the training that was provided.
3. Conduct weekly audits for at minimum six weeks following the service of this order, to ensure residents who require wander strips to be in place at their doorway are in place.
4. Maintain a record of the audits conducted, including residents and staff who were audited, the auditor, date(s) of the audits, results of the audit and any actions taken to address the audit findings.

Grounds

The licensee has failed to ensure that resident #007 was protected from abuse by resident #006 and resident #002 was protected from abuse by resident #001.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
(i) During an altercation, resident #006 pushed resident #007 while in a specified area, which caused resident #007 to fall. Resident #007 complained of pain, was transferred to the hospital and diagnosed with an injury.

Resident #006 had a history of demonstrating responsive behaviours towards staff and co-residents. This was verified by PSW #120, #121 and RPN #118. Behavioural Support Ontario (BSO) Lead #119, and Nurse Manger #109 also acknowledged that resident #006 exhibited the behaviour when anyone was in their personal space. Staff were re-direct co-residents away from resident #006. There were previous documented, instances when resident #006 attempted to hit co-residents who were in their personal space.

Surveillance footage of the incident showed an altercation in which resident #006 pushed resident #007, causing them to fall to the floor.

Nurse manager #109 verified the above-mentioned incident constituted physical abuse.

There was a physical impact on resident #007 when they were physically abused by resident #006.

Source: Clinical records of residents #006 and #007, Interviews with RPN # 118, PSW #120, BSO lead # and Nurse Manager #109, and Surveillance Footage.

[000709]

(ii) The RPN #102 found resident #002 sitting on floor in the hallway with an injury and a damaged personal item. RPN #102 and PSW #106 indicated resident #002 told them another resident hit them.

The home's video footage showed that resident #002 wandered into resident #001's room. Resident #001 approached resident #002 at the entrance and pushed resident #002, causing them to fall

Resident #001 indicated resident #002 had been entering their room on previous occasions and they informed the staff about this concern.

Nurse Manager #108 acknowledged resident #001 pushing resident #002 causing a fall which resulted in an injury was physical abuse.

The home failing to protect resident #002 from abuse from resident #001, resulted in injury.

Sources: Resident #001's and 002's clinical records, LTCH's video footage, interviews with resident #001, PSW #106, RPN #102, NM #108 and other staff.

[732787]

This order must be complied with by May 31, 2024

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 $11000.00, 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:

CO #001 under inspection #2023-1580-0003, issued June 06, 2023; and

CO #005 under inspection #2022-1580-0001, issued July 20, 2022.

This is the second AMP that has been issued to the licensee for failing 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.