Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto
District 5700 Yonge Street,
Sth Floor Toronto, ON, M2M
4K5

Original Public Report

Report Issue Date: September 18, 2024
Inspection Number: 2024-1580-0003
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Seven Oaks, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-30, 2024 and September 3-4, 2024

The following intake(s) were inspected:

- Intake: #00120867/Critical Incident (CI) #M571-OOOO23-24 - related to falls prevention and management
- Intake: #00124264/CI #M571-OOOO26-24/M571-OOOO27-24 - related to a resident who was missing for more than three hours

The following intake(s) were completed:

- Intake: #OO12O28O/CI #M571-OOOO19-24, intake: #OO12O768/CI #M571-OOOO22-24 and Intake: #00123956/CI #M571-000025-24 - related to falls prevention and management

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246722, s. 115 (1) 3.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
3. A resident who is missing for three hours or more.

The licensee has failed to ensure that a resident who was missing for three hours or more was reported to the Director immediately.

Rationale and Summary
A CI report regarding a resident who was missing for three hours or more was submitted to the Director the following day after the incident. A Registered Nurse (RN) stated that they did not contact the Service Ontario After-Hours Line to report that the resident was missing for three hours or more.

Failure to immediately report residents who were missing for more than three hours

to the Director may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CI report M571-OOOO26-24, interviews with staff.

WRITTEN NOTIFICATION: Emergency plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246722, s. 268 (4) 1. viii.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
viii. situations involving a missing resident,

The licensee has failed to ensure that the home's missing resident emergency plan was complied with.

In accordance with 0. Reg 246/22, s. 11 (1) (b), the licensee is required to have emergency plan in place to deal with situations involving a missing resident and must be complied with. Specifically, registered nursing staff did not comply with the home's Missing Resident — Code Yellow policy (EM-0501-00, published 15-12-2022) to initiate Code Yellow when the resident was missing for three hours or more.

Rationale and Summary
A resident left the home at a specific time and did not return at the expected time.

An RN stated that they received report from unit staff that the resident had not

returned to the home when it had already been three hours or more past the expected return time. Staff confirmed that Code Yellow was not called during their respective evening and night shifts when the resident was missing for three hours or more.

The home's Missing Resident — Code Yellow policy directed registered nursing staff to initiate Code Yellow when residents' whereabouts were unknown and cannot be accounted for.

A Nurse Manager verified that registered nursing staff were to initiate Code Yellow when the resident was missing for more than three hours. They verified that Code Yellow was not called until the following day and acknowledged that staff should have called Code Yellow when the resident was missing for three hours or more.

Failure to comply with the missing resident emergency plan placed the resident's safety at risk when they could not be located for an extended period of time.

Sources: A resident's clinical records, home's Missing Resident — Code Yellow policy (EM-0501-OO, published 15-12-2022) and interviews with staff.