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**
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# Original Public Report

**Report Issue Date:** June 21, 2024

**Inspection Number:** 2024-1580-0002

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** City of Toronto

**Long Term Care Home and City:** Seven Oaks, Scarborough

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 17, 20, 2024

The following intakes were inspected:

- Intake: #00111844 - Critical Incident System (CIS) #M571-000010-24 - Fall of a resident resulting in an injury
- Intake: #00112034 - Follow-up to Compliance Order (CO) #001, duty to protect from inspection #2024-1580-0001
- Intake: #00115359 - A complaint related to a resident's care needs

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1580-0001 related to FLTCA, 2021, s. 24 (1)

inspected by Jack Shi (760)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 2.**
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to ensure a resident's right to have their lifestyle and choices respected.

**Rationale and Summary:**
A complaint was submitted by the resident's substitute decision maker (SDM) to the Ministry of Long-Term Care (MLTC) regarding concerns over the home not allowing a resident to utilize a device for ambulation.

A review of the resident's chart indicated that an occupational therapist (OT) had assessed the resident and determined the resident not capable of using the device. However, in another OT assessment conducted outside of the home, it was determined the resident was capable of using this device.

The Physiotherapist (PT) stated that the home had offered the resident to use an alternate device for ambulation and had initially trialed this for the resident, but that the resident had declined and preferred their original method of ambulation.

A Nurse Manager (NM) acknowledged that the resident and their SDM had asked for a different OT assessment from the home to see if the resident was capable of using their preferred device for ambulation but that this was not done. The NM confirmed there were no other alternatives discussed with the resident or the SDM to identify an intervention to accommodate the resident's choice to continue using their preferred device for ambulation.

Failure to ensure uphold the resident's lifestyle and choices by identifying and trialing all opportunities in conjunction with the resident, led to a decreased quality of life for the resident.

**Sources:** Interview with the resident, the OT, the PT, a NM, a PSW and other staff; Resident's electronic clinical chart, including assessments and progress notes. [760]

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 failed to ensure that two PSWs utilized safe transferring techniques on a resident following their fall.

**Rationale and Summary:**
A Critical Incident Systems (CIS) report was submitted related a fall the resident sustained that resulted in an injury. Two PSWs both stated they had transferred the resident in a manner that did not align with the home's policy.

Failure to use appropriate lift techniques after the resident sustained a fall may have led to an increased risk of further complications to the resident's injury.

**Sources:** The home's policy, dated January, 2015; Interviews with two PSWs, the PT, and the NM. [760]