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: October 29, 2024
Inspection Number: 2024-1580-0004
Inspection Type: Proactive Compliance Inspection
Licensee: City of Toronto
Long Term Care Home and City: Seven Oaks, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 17, 18, 22, 23, 24, 25, 28, 2024

The following intake was inspected:

- Intake: #00129371 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(b) is on at all times;

The licensee has failed to ensure that the home was equipped with a resident staff communication and response system that was on at all times when the call bell system in a resident room was not functioning at the time of observation.

Rationale and Summary
A resident's call bell system in their bedroom and washroom were observed not working when activated.

A Registered Practical Nurse (RPN) and a Nurse Manager (NM) confirmed that there was an issue with the call bell system in the unit due to an unhooked connection

cord. On the same day, the NM confirmed that the call bell system in that resident's room was restored.

There was a risk of delayed response from the staff when the resident's call bell system was not on at all times.

Sources: Unit Observations, interviews with a RPN and a NM.

Date Remedy Implemented: October 17, 2024

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to comply with the system to ensure a resident's pain was addressed in accordance to the home's pain management program.

In accordance with O. Reg 246/22 s. 11 (1) (b), written policies and protocols were developed for the pain management system to provide strategies to manage pain and was required to be complied with.

Specifically, the licensee did not comply with the pain management policy titled, "Pain Assessment and Management", dated January 2020, which required staff to

refer to the physician (MD) after administering PRN (as needed) pain medication.

Rationale and Summary:
A resident had received a pain medication, twice during a specified period. The follow up assessment after initial the administration, indicated that both doses of the medication was ineffective.

As per the home's pain management policy, it had required staff to refer to the MD after administering PRN pain medication. There was no documentation to support that the ineffectiveness of the administration of pain medication was noted to the physician. A NM stated that the staff should have followed up with the effectiveness of the pain medication eariler. The NM also confirmed that the MD was not made aware that that the resident's pain medication was initially ineffective and acknowledged that the MD should have made aware of this issue.

Failure to follow up eariler on the effectiveness of a resident's PRN pain medication and informing the physician about the ineffectiveness of the PRN pain medication may result in lost opportunities to implement effective interventions to manage their pain.

Sources: A resident's progress notes and clinical chart; Home's policy titled, "Pain Management", dated April 2024; Interviews with a NM and other staff.

WRITTEN NOTIFICATION: No interference by licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 71 (a)
No interference by licensee
s. 71. A licensee of a long-term care home,

(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;

The licensee failed to ensure that the meetings of family council were not interfered by the licensee.

Rationale and Summary
The Family Council President indicated that they were concerned about holding virtual family council meetings in the home and that it did not work well to address the concerns in their meetings.

A review of the family council meetings indicated that in October and November 2023, the meetings were moved to an online format due to the home being in an outbreak. An administrator wrote an email to the family council president indicating that the family council meeting should be moved to an online venue because of the home's outbreak and recommendations from public health. A review of the recommendations from public health during that period did not specify that the area used for the meetings by family council should be restricted or limited. The Director of Nursing (DON) acknowledged that the former administrator had interfered with family council's ability to hold an in-person meeting in the home.

The interference of the family council's meetings from the licensee may result in possible decreased effectiveness at addressing the contents from their meetings.

Sources: Review of family council meetings; Email communications from an administrator to the Family Council President; Outbreak Management Team Meeting with Toronto Public Health in October 2023; Interview with the DON.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that two resident's altered skin integrity were reassessed at least weekly.

Rationale and Summary
i). A resident's written plan of care indicated that they had altered skin integrity.

A Registered Nurse (RN) stated that the resident's weekly wound assessment were missed five times during a specified period.

Sources: A resident's weekly wound assessments, interviews with a RN, a NM and the Skin and Wound Lead.

ii). Another resident's written plan of care indicated that they had altered skin integrity.

A NM and the Skin and Wound Lead stated that resident's with altered skin integrity including pressure injuries require weekly skin assessments using the Weekly Wound Assessment in Point Click Care (PCC). Both stated that the weekly skin assessments for the resident were missed for two specific periods.

There was a risk for delayed wound healing of two residents when their weekly skin assessments were not completed.

Sources: A resident's Weekly Wound Assessments, interviews with a NM and the Skin and Wound Lead.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, a clinically appropriate pain assessment tool was utilized.

Rationale and Summary
A resident was experiencing pain. A nurse had provided an intervention to the resident. The follow up documentation indicated that it was ineffective, and the resident continued to experience pain. The same intervention was provided again, to which the follow up documentation indicated that it was also ineffective.

A review of the resident's electronic clinical records did not demonstrate that a clinically appropriate pain assessment tool was utilized when the resident's pain was not relived by initial interventions. A NM states that the clinically appropriate comprehensive pain assessment tool could have been utilized for this resident.

Failure to utilize a clinically appropriate pain assessment tool to further analyze the root cause of the resident's pain may result in lost opportunities to implement effective interventions.

Sources: A resident's progress notes, assessments; Home's policy titled, "Pain Management", dated April 2024; Interview with the NM.

WRITTEN NOTIFICATION: Menu Planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

The licensee failed to ensure that a resident was offered a minimum of three meals daily.

Rationale and Summary
A resident complained to the Inspector that on one occasion, the staff did not provide them lunch.

The resident's Substitute Decision-Maker (SDM) confirmed that they informed the unit supervisor that the resident missed their lunch. After the home was made aware by the resident's SDM, the resident was offered a late meal, however, they opted to receive other options.

There was a risk of not meeting the resident's nutritional intake when the resident

was not offered their lunch.

Sources: A resident's progress notes, point of care documentation, interviews with a RPN, a NM, the resident and their SDM.

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a Food Service Worker (FSW) provided the planned menu items to a resident.

Rationale and Summary
A resident raised concerns that they did not receive a dinner roll. A review of the menu on that specified date, indicates that the dinner roll was offered as a lunch item. A FSW told the resident that the dinner roll had ran out on the unit and offered the resident another option, which was refused. The Nutritional Manager stated that there was no shortage of the dinner roll in the home and that the FSW should have contacted the kitchen for more dinner rolls if it ran out on the unit, rather than offering a substitute item for the resident.

Failure to ensure the planned menu items were offered to the resident may result in decreased quality of life for the resident.

Sources: The planned menu items; Interview with a resident and the Nutritional

Manager.

WRITTEN NOTIFICATION: Food production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee failed to ensure a FSW communicated to residents about a menu substitution.

Rationale and Summary
The home's menu indicated that pumpkin pie was to be served for lunch and pumpkin latte cake was to be served for dinner. A FSW had substituted and switched the pumpkin latte cake for lunch and pumpkin pie for dinner. The Nutritional Manager stated that the FSW did not communicate these changes to all the residents on the unit.

Failure to ensure that all residents were notified of a menu substitution may lead to residents not being aware of what they were being served.

Sources: The planned menu items; Interview with the Nutritional Manager.

WRITTEN NOTIFICATION: Medication management system

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the system to ensure two RPNs followed accurate administration of narcotic medications.

In accordance with O. Reg 246/22 s. 11 (1) (b), written policies and protocols were developed for the medication management system to ensure the accurate administration of all drugs used in the home and was required to be complied with.

Specifically, the licensee did not comply with the medication management policy titled, "Narcotic and Controlled Medications", dated January 2024, which required staff to document in the Narcotic & Controlled Drug Administration Record after the administration of a narcotic medication.

Rationale and Summary
i). The inspector had reviewed a RPN's Narcotic & Controlled Drug Administration Record binder and noted the count for the narcotic medications that were administered by the RPN on the same shift were not signed off. The RPN stated that their practice would be to sign off on the count once they complete their medication pass. The NM stated the home's policy indicates that the RPN should be completing the count right after the administration of the narcotic medication.

Sources: "Narcotic and Controlled Medications", dated January 2024; Observation on a RPN's narcotic medication cart and Narcotic & Controlled Drug Administration Record binder; Interview with a RPN and a NM.

ii). Another RPN was observed administering a resident's narcotic medication. The RPN was not observed signing in the Narcotic & Controlled Drug Administration Record binder after completing the administration of the resident's medication and had moved onto the next resident. The RPN stated they were unaware what the home's policy required them to do. A NM stated in accordance to the policy, the RPN should have signed the narcotic binder after administering the narcotic to the resident.

Failure to ensure that the Narcotic & Controlled Drug Administration Record was signed after administering a narcotic may lead to discrepancies with the number of narcotics.

Sources: The medication management policy titled, "Narcotic and Controlled Medications", dated January 2024; Observation on a RPN's medication administration; Interview with a RPN and a NM.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

The licensee failed to ensure that a written record was completed on the role of Resident Council's actions, if any, undertaken by the home's annual Continuous Quality Improvement (CQI) report.

Rationale and Summary
A review of the home's 2023 CQI reports did not produce any information on the actions, if any, that were undertaken by the Resident's Council. The Administrator confirmed that the home's previous administrator did not document the roles of Resident Council's actions, if any, in the CQI report and/or any other documentation to support that this was put in a written record.

Sources: Home's CQI report for 2023; Interview with an Administrator.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure that a written record was kept related to the communication to residents and their families along with the members of staff in the home about on the actions undertaken from the CQI report.

Rationale and Summary

A review of the home's internal records did not demonstrate that there was a written record on the communication of actions undertaken from the 2023 CQI report to residents and their families along with the members of staff in the home. The Administrator was unable to produce written documentation to support that the home's previous administrator had communicated this information to the residents and their families along with the members of staff in the home.

Sources: Various internal home records related to the 2023 CQI report; Interview with an Administrator.