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

Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1580-0002

Inspection Type:
Other
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Seven Oaks, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 4-6 and 10, 2025.

The following intakes were inspected in this Critical Incident inspection:

- Intake: #00135887 - Critical Incident System (CIS) #M571-000053-24 related to a fall with an injury;
- Intakes: #00138605, 00140325, 00141201 - CIS #M571-000007-25, M571-000009-25, M571-000012-25 related to an outbreak;
- Intake: #00139219 - related to the home's emergency planning annual attestation;
- Intake: #00140405 - CIS #M571-000010-25 related to an alleged incident of abuse.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and 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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed. A resident's written plan of care indicated the use of an intervention for falls prevention. The resident was observed without the intervention in place. The Acting Director of Nursing (DON) indicated the resident no longer required this intervention and that the written plan of care should be updated to reflect their current care needs.

The written plan of care was revised on March 6, 2025, to have the falls prevention intervention removed.

Sources: A resident's written plan of care; Observations; Interview with the Acting DON.

Date Remedy Implemented: March 6, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of 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 a Registered Nurse (RN) collaborated with a Registered Practical Nurse (RPN) in the implementation of a resident's plan of care. A resident was demonstrating responsive behaviours. They had an intervention in place for their responsive behaviours. A RPN documented that they had attempted to provide this intervention to the resident, but it was refused. The RN had intervened in this situation but failed to attempt to provide the resident this intervention. The Acting DON confirmed that the RN failed to collaborate with the RPN in implementing the resident's plan of care as it related to their responsive behaviours.

Sources: Interviews with a RN and the Acting DON; A resident's progress notes and plan of care.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that a RN complied with the home's policy to promote zero tolerance of abuse and neglect of residents. The home's abuse policy indicated that for any alleged incident of staff to resident abuse, that it should be reported. A RN documented that a resident alleged that staff were abusing them. The Acting DON indicated that the RN failed to report these allegations to the Registered Nurse In-Charge (RNIC) and did not comply with the home's abuse policy.

Sources: Interviews with a RN and the Acting DON; Home's policy titled, "Zero tolerance of abuse and neglect of residents", dated June 2024; a resident's progress notes.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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 staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program. A resident home area

was on an outbreak, and part of the home's IPAC program required all staff to wear eye protection when they were on the outbreak unit and interacting with residents. Two Personal Support Workers (PSW) and one agency PSW were all seen without wearing eye protection while they were carrying out their duties on the unit.

Sources: Observations; Interviews with the IPAC Manager, the Acting DON, two PSWs, an Agency PSW and the RN.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that a resident's symptoms were recorded on each shift when they were diagnosed with a respiratory illness. A review of the documentation indicated that the resident's assessments and/or symptoms were not documented for various shifts, while the resident was actively exhibiting symptoms and on isolation precautions.

Sources: Review of resident's assessments and progress notes from PCC; Interviews with the IPAC Manager and the Acting DON.

WRITTEN NOTIFICATION: Attestation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee has failed to ensure that the attestation for emergency planning was submitted annually to the Director. The Administrator and the Acting DON confirmed that the home's emergency planning attestation form was not submitted to the Director annually by December 31, 2024..

Sources: Home's emergency planning attestation form; Interviews with the Administrator and the Acting DON.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 102 (2) (b) [FLTCA, 2021, s. 155 (1) (b)]:

The plan shall include but is not limited to:

1. Develop and implement a process to audit and monitor the IPAC practices of the staff on the third floor unit. The process should identify the individual that will

oversee the audits and monitoring of the staff on the third floor unit and the frequency of these audits and monitoring.

2. Actions that would be taken by the home when staff on the third floor unit are observed to be non-complainant with the required IPAC measures.

3. Identify any potential education gaps with the IPAC practices of the third floor staff and measures undertaken to address these gaps in their knowledge of proper IPAC practices.

Please submit the written plan for achieving compliance for inspection #2025-1580-0002 to LTC Homes Inspector, MLTC, by email by March 25, 2025.

Grounds

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

i). In accordance with Additional Requirement 10.4 (h) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that residents on the third floor unit were provided or offered hand hygiene by the staff prior to their meal. Three PSWs did not provide or offer residents with hand hygiene prior to providing them their meals. The IPAC Manager and the Acting DON stated the home's expectations would be for the PSWs to offer or provide hand hygiene to residents immediately prior to getting their meals.

Failure to provide hand hygiene to residents prior to their meals may result in further spread of infectious diseases.

Sources: Observations; Interviews with three PSWs, the IPAC Manager and the Acting DON.

ii). In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that a PSW followed the four moments of hand hygiene. A PSW was observed coming out of a resident's room who was on isolation precautions after delivering the resident's meal but did not perform hand hygiene until prompted by the inspector. The IPAC Manager and the Acting DON stated the home expected the PSW to adhere with the four moments of hand hygiene and to perform hand hygiene after delivering the meal for the resident.

Failure to ensure that the four moments of hand hygiene was followed may result in further spread of infectious diseases.

Sources: Observations; Interviews with a PSW, the IPAC Manager and the Acting DON.

iii). In accordance with Additional Requirement 9.1 (d) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure a PSW properly utilized personal protective equipment when interacting with a resident on isolation precautions. A resident was placed on additional precautions and a PSW was observed doffing their gloves while inside the resident's room. Afterwards, the PSW continued to prepare the resident for their meal without their gloves on. The IPAC Manager and the Acting DON stated the PSW should have kept their gloves on when they were inside the resident's room setting up their food tray.

Failure to ensure that proper utilization of PPE was adhered to may cause further spread of infectious diseases to residents.

Sources: Observations; Interviews with a PSW, the IPAC Manager and the Acting DON.

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This order must be complied with by April 25, 2025

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.