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

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Public Report

Report Issue Date: July 10, 2025
Inspection Number: 2025-1580-0004
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 dates: July 8, 9, 10, 2025.

The following intakes were inspected:

- Intake: #00147622- Critical Incident System (CIS) # M571-000017-25 related to a communicable disease outbreak;
- Intake: #00149965- CIS # M571-000020-25 related to a communicable disease outbreak;
- Intake: #00151373- CIS # M571-000021-25 related to an allegation of abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect by a Personal Support Worker (PSW). A PSW had used an inappropriate method of communication with the resident. The PSW acknowledged that they did not treat the resident with courtesy and respect during that interaction.

Sources: Progress notes; Interviews with a PSW, a resident and other staff.

WRITTEN NOTIFICATION: Personal care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee has failed to ensure that a PSW provided personal care to a resident. A resident had stated that they did not receive personal hygiene care to an area of their body. The PSW confirmed that they were not able to provide personal hygiene care to the resident in that area.

Sources: Progress notes; Interview with a PSW and other staff.

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 a PSW utilized safe transferring techniques with a resident. A PSW had utilized a transfer method with a resident that did not align with their assessed needs. Later that same day, the PSW utilized this same transfer method again and it resulted in the resident sustaining a fall.

Sources: Progress notes; Home's investigation notes; A resident's care plan; Interviews with two Registered Practical Nurses (RPNs), a resident and other staff.

WRITTEN NOTIFICATION: Menu planning

NC #004 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 has failed to ensure that a resident was offered a lunch meal. A resident left the home for a planned activity in the community and wanted to have their lunch upon their return. A PSW confirmed that the resident did not receive their lunch meal when they returned to the home.

Sources: Home's investigation notes; Progress notes related to the incident; Interview with a PSW and other staff.