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: September 8, 2025
Inspection Number: 2025-1580-0005
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): September 3, 4, 8, 2025.

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00152558 (M571-000023-25) and intake: #00154265 (M571-000025-25) - related to falls with an injury.
- Intake: #00153763 (AH-2025-0000613/M571-000024-25) - related to a communicable disease outbreak.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care set out clear directions to staff related to their ambulation status. The resident's plan of care indicated that they required a level of assistance prior to a fall. A Nurse Manager (NM) confirmed that plan of care did not provide clear directions to the staff because the resident did not always require that level of assistance.

Sources: A resident's plan of care; Interview with a NM. [760]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was implemented.

In accordance with the “IPAC Standard for Long-Term Care homes April 2022”, under section 9.1D, routine practices are followed in the IPAC program. At minimum routine practices shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal. On a day in September 2025, a Personal Support Worker (PSW) did not select and apply the correct PPE before entering a room to assist a resident requiring additional precautions. An IPAC Manager confirmed that PPE was not donned in the correct manner as per IPAC standard.

Sources: observation on the fourth floor; interviews with a PSW and an IPAC Manager. [740849]