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 31, 2023	
Inspection Number: 2023-1580-0005	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Seven Oaks, Scarborough	
Lead Inspector Britney Bartley (732787)	**Inspector Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2023.11.06 10:12:35 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 5, 6, 12, 13, 16-18, 20, 23, 2023

The following intake(s) were inspected:

- Intake: #00095814 - Fall of a resident resulting injury.
- Intake: #00097158 - Was a complaint related to injuries of unknown cause, responsive behaviours and alleged abuse.
- Intake: #00097197 - Was related to injuries of unknown cause.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (10) (b)

The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when a resident's care needs changed.

Rationale and Summary

On a specific day Personal Support Worker (PSW) #111 reported to Registered Nurse (RN) #105 and Registered Practical Nurse (RPN) #106 that a resident had evidence of potential injuries.

RPN #106 and PSW #114 both indicated on the previous day, the resident was wandering the unit and demonstrated responsive behaviours. RPN #106 and PSW #114 also indicated the resident was observed having altercations with a co-resident, RPN #106 intervened to separate both residents.

Staff indicated the resident demonstrated the above behaviours over the past several months. PSWs #111 and #113 stated they would redirect the resident when the resident had responsive behaviours.

The resident's written plan of care did not direct staff on how to manage the resident's behaviours until after the resident was found with the above potential injuries.

Nurse Manager (NM) #108 and Behavioral Support Nurse (BSO) #107 both indicated the resident's care plan should have been updated to include interventions to manage the resident's behaviours.

By staff failing to revise and update the resident's plan of care there was potential risk of staff not knowing how to manage the resident's responsive behaviours.

Sources: A resident's clinical records, interviews with NM #108, BSO #107, RN #105, RPN #106, PSWs #111, #113, #114 and other staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that resident #001's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care when they did not notify the SDM regarding an incident involving a co-resident.

Rationale and Summary

A resident's care giver was walking by resident #001's room when they witnessed an altercation between resident #002 and resident #001. When approached by the care giver resident #001 indicated resident #002 wanted to hurt them. The caregiver reported this incident to a RN.

The RN completed a head to-toe assessment and observed there was no injury to the resident #001. Six days after the incident a RN called resident #001's SDM to inform them about another matter, the SDM inquired why they were not informed of the altercation between resident #002 and #001. The RN apologized for not informing the SDM when it had happened.

The RN indicated they called the SDM when the incident occurred but could not inform them because they were unable to reach the SDM. The RN confirmed the attempted phone call to inform the SDM was not documented.

NM #108 indicated the resident-to-resident altercation should have been reported to the SDM. If staff were unable to reach the SDM, staff were to endorse to the oncoming shift and document all attempts.

When staff failed to notify the resident's SDM of the resident-to-resident altercation it may have delayed the SDM's participation in the development of the plan of care.

Sources: A resident's clinical records, interviews with NM #108, RN, and a care giver.

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