

## 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: January 15, 2025

**Inspection Number:** 2025-1580-0001

**Inspection Type:** 

Complaint

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): January 8, 9, 10, 14, and 15, 2025.

The following Critical Incident System (CIS) intake(s) were inspected:

• Intake #00135526 related to infectious disease outbreak.

The following Complaint intake(s) were inspected:

• Intake #00136123 related to prevention of abuse and neglect.

The following intake(s) were completed:

• Intake #00132309 related to infectious disease outbreak.

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

Infection Prevention and Control Prevention of Abuse and Neglect

### **INSPECTION RESULTS**



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#### **WRITTEN NOTIFICATION: Plan of care**

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's behavioural plan of care was provided to the resident as specified in the plan. According to the plan, when the resident exhibits responsive behaviours, care should be provided with a specified assistance. However, on one occasion, the required assistance was not provided to the resident when they demonstrated such behaviours.

**Sources:** Resident's progress notes, care plan; interviews with a RPN, PSW, RN, and the Acting DON.



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