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: May 16, 2025

Inspection Number: 2025-1580-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: City of Toronto

Long Term Care Home and City: Seven Oaks, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6-9, 13-16, 2025

The following intake(s) were inspected:

- Intake: #00140992 - a complaint related to allegations of financial abuse
- Intake: #00141887/ Critical Incident (CI) #M571-000013-25 - related to improper care
- Intake: #00142015 - follow-up on a previously issued Compliance Order (CO) related to Infection Prevention and Control (IPAC)
- Intake: #00143299/CI #M571-000014-25 - related to prevention of abuse and neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1580-0002 related to O. Reg. 246/22, s. 102 (2)

(b)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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 staff used safe transferring and positioning techniques when assisting a resident. A Personal Support Worker used improper transfer techniques when assisting the resident back to bed which resulted in an injury to the resident.

Sources: Resident's clinical records, home's investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated ongoing responsive behaviours towards other residents, actions were taken to respond to the needs of the resident. The resident was not assessed, nor were the resident's responses to interventions documented to identify the effectiveness of the interventions. An incident occurred between the resident and a co-resident which resulted in the injury to the co-resident.

Sources: Resident's clinical records and interviews with staff.