

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

Toronto Service Area Office  
5700 Yonge Street 5th Floor  
TORONTO ON M2M 4K5  
Telephone: (416) 325-9660  
Facsimile: (416) 327-4486

Bureau régional de services de  
Toronto  
5700, rue Yonge 5e étage  
TORONTO ON M2M 4K5  
Téléphone: (416) 325-9660  
Télécopieur: (416) 327-4486

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 2, 2021	2021_939757_0005	008415-21, 018583-21	Critical Incident System

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**Licensee/Titulaire de permis**

Better Living at Thompson House  
1 Overland Drive Toronto ON M3C 2C3

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**Long-Term Care Home/Foyer de soins de longue durée**

Better Living at Thompson House  
1 Overland Drive North York ON M3C 2C3

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

RODOLFO RAMON (704757)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 22-25, 2021**

**The following intake was completed in this Critical Incident System (CIS) inspection:**

**Log #008415-21, CIS #3017-000002-21 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Infection Prevention and Control (IPAC) lead, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).**

**During the course of the inspection, the inspector conducted observations of resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

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

**Infection Prevention and Control**

**Medication**

**Personal Support Services**

**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**3 WN(s)**

**3 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home  
Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that shower room doors were kept closed and locked when they were not being supervised by staff.

The inspector observed shower room doors on the second, third and fourth floors which were unlocked and unsupervised. Staff #103 and #100 acknowledged that all shower room doors were expected to be locked when not supervised by staff. The DOC also confirmed that shower rooms were areas that were required to be locked unless supervised, for the safety of the residents.

Sources: Observations, interviews with staff #100, staff #103, and DOC. [s. 9. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that shower doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**

**(a) drugs are stored in an area or a medication cart,**

**(i) that is used exclusively for drugs and drug-related supplies,**

**(ii) that is secure and locked,**

**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**

**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**

**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

Inspector #704757 observed a medication cart in a hallway to be unlocked and unattended in the presence of residents, placing residents at risk of ingesting medications. Staff #101 acknowledged that the medication cart was required to be locked when unattended. On a separate observation, staff #102 was seen leaving the medication cart unlocked and unattended. Staff #102 acknowledged that the medication cart should have been locked. The DOC stated that staff were expected to lock all medication carts when left unattended.

Sources: Observations, interviews with staff #101, staff #102, and DOC [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

Inspector #704757 observed staff providing meal service to residents without assisting them with hand hygiene. Staff stated that they were expected to assist residents with hand hygiene but assistance was not always provided due to workload constraints. The IPAC lead acknowledged that no assistance was provided during the inspector's observations, which placed residents at risk of transmitting and acquiring infectious diseases.

Sources: Observations, interviews with staff #100 and IPAC lead [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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Issued on this 20th day of December, 2021

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**