Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
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Original Public Report

Report Issue Date August 17, 2022
Inspection Number 2022_1512_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Better Living at Thompson House

Long-Term Care Home and City
Better Living at Thompson House
1 Overland Drive, North York

Lead Inspector
Ivy Lam (646)

Inspector Digital Signature
Ivy Lam
2022.08.23 17:34:31 -04'00'

Additional Inspector(s)
Oraldeen Brown (698)
Inspector #741073 (Ryan Randhawa) was also present during this inspection.

INSPECTION SUMMARY

The Proactive Compliance Inspection (PCI) occurred on the following dates: July 20, 21, 22, 25, 26, 28 and 29, 2022.

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22, s. 168 (2) 5 (iii)

The licensee has failed to ensure that the Continuous Quality Improvement Initiative report included how, and the dates when the actions taken from the Resident and Family Experience Survey were communicated to residents' families.

The Administrator indicated that the survey gathered responses of residents and family members, and the survey results were communicated to residents and staff, but not to the families. The Administrator was not aware that the survey results were not communicated to family members until July 26, 2022, after interview with the inspector.

On July 29, 2022, a letter with the Resident and Family Experience Survey 2021 results were sent out by the Administrator to family members by electronic mail.

Sources: Resident and Family Experience Survey 2021, Resident and Family/Caregiver Experience Survey 2021 Results, July 29, 2022 – Family member communication; Interviews with Program Manager, and the Administrator

Date Remedy Implemented: July 29, 2022

[646]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6(4)(a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the pain assessment of a resident, so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident was injured during transfer and reported pain. The Registered Nurse (RN) who responded to the incident did not complete an incident report or a pain assessment.

The resident continued to experience pain after the incident and was provided with as needed (PRN) pain medication for 23 times in 26 days. No pain assessment was completed for the resident when the PRN pain medication was provided to them.

A physiotherapist (PT) referral was submitted after the incident for the resident's pain. The PT did not review the resident's previous assessment or progress notes to see that this was a new injury to the resident. The PT indicated they would have referred the resident to x-ray assessment to rule out other injuries had they been aware this was a new injury and would have provided different treatment for the resident.

The Assistant Director of Nurse (ADON)/Pain Lead indicated that the pain assessment should have been done after the incident, and the physician (MD) consulted when the resident continued to experience pain.

The Director of Nurse (DON) indicated there was a lack of collaboration in the assessment of the resident's pain after their injury.

There was minimal harm experienced by the resident as they received PRN pain medication 23 times in 26 days when registered staff did not collaborate with the PT in the assessment of the resident's injury.

Sources: Resident's progress notes, resident's electronic Medication Administration Report (eMAR), Physiotherapy assessment, observations of resident #006 and staff interactions; interviews with the resident, PT, ADON/Pain Lead, DON, and other staff.

[646]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#03 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 a resident was reassessed, and the plan of care reviewed and revised when the resident's nutritional care needs changed.

Rationale and Summary

A resident was to receive a texture-modified diet with regular fluids. Observations of the resident showed the resident was provided with a different texture-modified diet with thickened fluids.

Two PSWs indicated the resident had been having difficulty with previous texture-modified diet with regular fluids and had been receiving the different texture-modified diet with thickened fluids.

An RN and the Food Service Manager (FSM) indicated the resident should have been reassessed by the Registered Dietitian (RD) and care plan should have been updated when the resident was no longer able to tolerate their previous diet texture and fluids.

The resident was at risk of not receiving the appropriate diet texture when they were not assessed for a texture change and had their care plan updated.

Sources: The resident's care plan, Meal Distribution List, progress notes; Observations of the resident at mealtimes; Interviews with PSWs, RN, and FSM, and other staff.

[646]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 65 (7) (b)

The licensee has failed to ensure that the home convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council when there was no Family Council in the home.

Rationale and Summary

The home did not have a Family Council since 2018. The Administrator indicated that there were no records of communication to family members, or persons of importance to residents, regarding their right to establish Family Council in the home. No meetings were held with family members regarding establishing a Family Council between 2018 to the time of the inspection in July 2022.

Sources: Continuous Quality Improvement Initiative report, Resident and Family/Caregiver Experience Survey, Residents' Council meeting minutes; Interviews with Program Manager, and the Administrator.

[646]

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WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

[**Non-compliance with: O. Reg. 246/22, s.57 (2)**

The licensee has failed ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

The home's policy indicated that pain assessment was to be done when a resident exhibited a change in health status or if their pain was not relieved by initial interventions, including when a resident was taking pain-related medication for greater than 72 hours.

A resident had requested PRN pain medication 23 times in 26 days, in addition to their scheduled pain medication. No pain assessment was completed for the resident during the month when they had requested the pain medication.

The resident indicated that they continued to have daily pain and continued to request for pain medication. The resident indicated they would prefer to have their pain medication on a schedule so they would not have to ask nurses to provide medication when they had pain.

The ADON/Pain Lead indicated that the pain assessment should have been completed for the resident when the resident was provided with PRN pain medication but continued to have pain for greater than 72 hours. They further indicated a referral should have been made to the physician and/or pain lead for further assessment of pain and reassessment of pain medications.

There was a risk that the resident's pain was not properly assessed, and timely and appropriate referral and treatment was not provided for the resident when the resident's pain was not assessed using the clinically appropriate pain assessment instrument.

Sources: The resident's care plan, progress notes, Home's Pain Management Program policy; Observations of the resident and staff interactions; Interviews with the resident, and the ADON/Pain Lead.

[646]