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

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Original Public Report

Report Issue Date: February 8, 2023
Inspection Number: 2023-1512-0003
Inspection Type: Complaint Critical Incident System
Licensee: Better Living at Thompson House
Long Term Care Home and City: Better Living at Thompson House, North York

Lead Inspector	**Inspector Digital Signature**
Matthew Chiu (565)	Matthew Chiu Digitally signed by Matthew Chiu Date: 2023.02.10 14:29:41 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 23, 2023
January 24, 2023
January 25, 2023
January 26, 2023
January 27, 2023
January 30, 2023
January 31, 2023
February 1, 2023

Inspector Irish Abecia (000710) was present during this inspection.

The following intake(s) were inspected:

- Intake: #00014286 related to falls prevention and management;
- Intake: #00015666 related to prevention of abuse; and
- Intake: #00017703 complaint related to authorization for admission to a home.

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

Infection Prevention and Control
Admission, Absences and Discharge
Falls Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from sexual abuse.

Rationale and Summary:
For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

An alleged resident to resident sexual abuse was reported to the Ministry of Long-Term Care (MLTC). During a shift, staff observed two residents performing an activity in a sexual nature. They were separated by staff, and no injury was found on both residents. The resident was confused and there was no evidence indicating they were capable to consent to the above-mentioned sexual behaviour.

The home's failure to protect the resident from sexual abuse caused a risk of harm to their health and wellbeing.

Sources: Home's investigation records, residents' progress notes and care plans; interviews with the Personal Support Worker (PSW), Registered Practical Nurse (RPN), Assistant Director of Nursing (ADON) and other staff. [565]

WRITTEN NOTIFICATION: AUTHORIZATION FOR ADMISSION TO A HOME

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7)

The licensee has failed to approve an applicant's admission to the home under FLTCA, 2021, s. 51 (7). As outlined in FLTCA, 2021, s. 51 (7), the licensee shall approve the applicant's admission to the home unless:
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Rationale and Summary:
The MLTC received a complaint related to bed refusal from the home. The applicant had a specified care requirement and there was a plan for managing the requirement.

Record review and staff interviews indicated that the home initially approved the applicant's admission as they felt they could meet the care needs for the applicant. As they were making arrangements to support the applicant's care needs, they identified a specified concern if they admitted the applicant. Therefore, the home withheld the approval for the applicant's admission to the home.

The home had the nursing expertise to engage their health partners to provide in-service education to their nursing staff in meeting the care requirements of the applicant, and that they are within the scope of nursing in long-term care. The Director of Nursing (DON) acknowledged that the home did not meet the conditions stated under FLTCA, 2021, s. 51 (7) for withholding approval, and they failed to approve the applicant's admission to their home.

Sources: Applicant's admission application records; interviews with the complainant and DON. [565]

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) (c)

The licensee has failed to ensure that a resident's falls prevention plan of care was revised when the care set out in the plan had not been effective.

Rationale and Summary:
A CIS report indicated that the resident had a fall and sustained a significant injury.

The resident's falls prevention plan of care had a specified goal and the care set out in the plan was last revised approximately three months prior to the above-mentioned fall. During this period, the resident sustained multiple falls, and their risk for falls was changed. Since their risk had changed and their falls prevention care was not meeting their goal, the care set out in the plan was ineffective to prevent the resident from falling, and they continued to fall and sustained the significant injury as mentioned above. Record review and staff interviews confirmed that the care set out in the resident's falls prevention plan of care was not revised when the care set out in the plan had not been effective.

The non-compliance caused a risk of harm to the resident when managing their falls prevention.

Sources: Resident's progress notes and care plan; interviews with the PSW, Registered Nurse (RN), Physiotherapist (PT), ADON and other staff. [565]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee has failed to ensure that a staff who provided direct care to a resident was aware of the content of the resident's behavioural plan of care and had convenient and immediate access to it.

Rationale and Summary:
The resident had a history of demonstrating a type of responsive behaviour. The home had implemented a behavioural plan of care for the resident, and it included a specific intervention in the resident's care plan.

A PSW was supposed to access a specified type of care plan tailored to the PSW. Staff interviews and record review confirmed that a direct care staff member was unaware of the above-mentioned behavioural plan of care for the resident. It was further confirmed that they did not have convenient and immediate access to the resident's specified behavioural plan.

The non-compliance of staff not being aware of the resident's behavioural interventions in their plan of care and had no convenient and immediately access to it caused a risk of harm to other residents when managing the resident's behaviours.

Sources: Resident's care plan and Kardex; interviews with the PSW, RN, Behavioural Support Lead (BSL) and ADON. [565]