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

Original Public Report

Report Issue Date: October 5, 2023	
Inspection Number: 2023-1512-0004	
Inspection Type: Critical Incident	
Licensee: Better Living at Thompson House	
Long Term Care Home and City: Better Living at Thompson House, North York	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.10.24 16:29:06 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 13, 25-27, 2023.

The following intake(s) were inspected:

- Intake: #00019590 was related to an unknown fracture.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that clear directions were in the written plan of care related to falls for

a resident.

Rationale and Summary:

The resident's care plan mentioned an identified fall intervention which was observed in use.

A staff stated that the resident's fall intervention was implemented in a specific manner. Registered Nurse (RN) #106 stated that the fall intervention was implemented in a different manner. Assistant Director of Nursing (ADON) #100 advised they had observed staff using the fall intervention inconsistently. The resident's care plan did not provide clear directions to staff on the correct use of the fall intervention.

Failure to provide clear directions to direct care staff on the correct use of the fall intervention put the resident at risk of not having the intervention correctly implemented.

Sources: Observations of resident; Resident's care plan and interviews with staff.

[741674]

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that a resident's responses to pain management were documented.

Rationale and Summary:

(i) The resident was identified with an injury and pain was noted with movement. Staff contacted the Medical Doctor (MD) who provided direction to continue with the medication for pain.

The home's policy directed registered nursing staff to implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions (e.g. positioning, distraction, relaxation, massage, aroma therapies, heat and cold) and to document the effectiveness of the interventions.

The resident's electronic medical administration record (eMAR) indicated that the resident was administered pain medication in the evening of an identified date and in the morning the next day.

(ii) On a later date, the resident was identified with increased pain with movement. RN #108 documented that a note was written in the MD's communication book for their next visit. The resident was not provided with any pharmacological or non-pharmacological pain interventions.

Two registered staff stated they were aware that resident #001 was administered pain medication but had not documented the resident's responses to the effectiveness of the pain medication. ADON #100 confirmed that the expectation of the staff was to document the resident's response to the pain medication after they were identified with increased pain upon movement.

Failure to document the resident's response to the pain medication put them at risk of not knowing the effectiveness of the medication in managing the resident's pain.

Sources: Resident's eMAR, resident's progress Notes; Pain Management Policy (N0006-004) effective March 2014; Interviews with staff. [741674]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that a resident's pain was assessed using a clinically appropriate assessment instrument.

Rationale and Summary:

A resident was administered pain medication when they were identified with pain. Two hours later, a clinically appropriate instrument titled pain assessment was completed.

Three day later, RN #108 identified that the resident continued to exhibit pain. However, a clinically appropriate instrument was not completed when the resident exhibited pain. Ten hours later the resident was in severe pain and was transferred to hospital.

RN #108 confirmed that resident's pain was not assessed when the resident continued to exhibit pain. ADON #100 indicated the expectation of the staff was to complete a pain assessment when a resident exhibited pain. They acknowledged that a pain assessment using a clinically appropriate instrument was not completed.

Failure to assess the resident's pain using a clinically appropriate assessment instrument put them at risk of delayed interventions to manage pain.

Sources: Resident's progress notes; Interviews with staff.

[741674]