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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 4, 2024

Inspection Number: 2024-1512-0001

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	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.05.01 15:39:03 -04'00'

Additional Inspector(s)
Emily Rong (000827) was present during this inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 12-15, 18-20, 2024

The following intakes were inspected in this CI (Critical Incident) inspection:

- Intake: #00105096 [CI: 3017-000013-23] - related to a disease outbreak
- Intake: #00107711 [CI: 3017-000003-24] - related to a fall of a resident resulting in injury
- Intake: #00107718 [CI: 3017-000004-24] - related to resident-to-resident abuse

The following intakes were completed in this CI inspection:

- Intake: #00106285 [CI: 3017-000001-24] - related to a fall of a resident resulting in injury
- Intake: #00109176 [CI: 3017-000006-24] - related to a disease outbreak

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care for the residents were documented.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to two residents demonstrating behaviours.

The resident was observed demonstrating behaviours towards the other resident.

The staff on a resident home area provided the care set out in the plan of care to the residents as specified in the plan.

A review of the residents' clinical records revealed that the provision of care observed was not documented.

A Registered Nurse (RN) confirmed that the incident between the residents were not documented. A Behavioural Support Lead confirmed that staff were expected to document the demonstrated behaviours of both residents. The Associate Director of Care (ADOC) acknowledged that the staff were expected to provide the care set out in the residents' plan of care and document the provision of care.

Failure to ensure that the provision of care set out in the plan of care for both residents were documented could lead to the staff's inability to monitor the residents for escalated behaviours.

Sources: CIR #3017-000004-24; Observations of both residents; Residents' clinical records; Interviews with staff.

[000710]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when the home did not conduct weekly Infection Prevention and Control (IPAC) Self-Assessment Audit for Long-Term Care and Retirement Homes during a COVID-19 outbreak in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario; IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes must be completed weekly when a home was in a COVID-19 outbreak.

Rationale and Summary
A Local Public Health Unit (PHU) declared a COVID-19 outbreak at the home. The IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes was not completed for a three week period.

The IPAC Lead acknowledged that the IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes was not completed weekly during the outbreak.

Failure to complete the IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes weekly during a COVID-19 outbreak could lead to the home's inability to identify gaps in their IPAC measures and may lead to further infection transmission.

Sources: Home's IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes; Summary letter; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in

Ontario; And interview with the IPAC Lead.

[000710]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when a COVID-19 outbreak was declared at the home.

Rationale and Summary
A local PHU declared a COVID-19 outbreak at the home on a specified date. A CIR was submitted to the Director 13 days later.

The IPAC Lead confirmed that the COVID-19 outbreak was not reported immediately to the Ministry of Long-Term Care.

Failure to immediately inform the Director of the COVID-19 outbreak may have delayed follow up by the Ministry of Long-Term Care.

Sources: CIR #3017-000013-23; Email communication from the local PHU; and Interview with the IPAC Lead.

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