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: November 18, 2024

Inspection Number: 2024-1512-0002

Inspection Type:
Critical Incident

Licensee: Better Living at Thompson House

Long Term Care Home and City: Better Living at Thompson House, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 25, 28, 29, 2024

The following intake(s) were inspected:

- Intake: #00122090 / Critical Incident Systems (CIS) #3017-000009-24 was related to COVID-19 outbreak
- Intake: #00125486 / CIS #3017-000014-24 was related to falls
- Intake: #00129346 / CIS #3017-000017-24 was related to late reporting and falls

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

Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Food and Nutrition

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and prevent food borne illness for a resident.

Rationale and Summary
A resident's meal was observed on a table for more than an hour. The beverages were uncovered, the food was partially covered and an insect was observed on the food.

Two Personal Support Workers (PSWs) both indicated that they were responsible for serving the resident and acknowledged that when the food was not properly covered, left for over an hour, and an insect was observed on the resident's food, did not preserve taste, nutrition value, and prevent food borne illness.

Failure to serve food in a way that preserves taste, nutrition value, food quality, and prevent food borne illness may reduce the pleasurable dining experience for the resident.

Sources: observation of the resident's meal tray, electronic health records,

interviews with the two PSWs and others.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition was reported to the Director within one business day.

Rationale and Summary
A resident experienced a fall resulting in an injury that required medical attention. They were transferred to hospital and underwent surgical procedures. The home became aware of the resident's diagnosis on the same day of transfer to hospital but did not submit a Critical Incident Systems (CIS) within the required time frame.

The Director of Care (DOC) acknowledged that a CIS should have been submitted within one business day of the resident's injury.

There was no impact or risk to the resident related to the late submission of the CIS report to the Director.

Sources: CIS report # 3017-000017-24, review of the resident's health care records, and interview with the DOC.

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