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

Public Report

Report Issue Date: March 24, 2025

Inspection Number: 2025-1512-0001

Inspection Type:
Complaint
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): March 11 - 14, 17 - 20, 24, 2025

The following Complaint intake(s) were inspected:
- Intake: #00137684 - Related to physical abuse, neglect, injuries of unknown cause, follow-up from home

The following Critical Incident (CI) intake(s) were inspected:
- Intakes: #00140174 [CI #3017-000007-25] and #00142151 [CI #3017-000009-25] – Related to disease outbreaks
- Intake: #00141095 [CI #3017-000008-25] – Related to a fall with injury

The following intakes were completed - #00136460 [CI #3017-000001-25] and #00137165 [CI #3017-000002-25] related to disease outbreaks.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Infection Prevention and Control
Safe and Secure Home
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 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. On a specific date, a resident sustained injuries to specific parts of their body. On the same day, a Registered Nurse (RN) spoke with the resident's substitute decision-maker (SDM) about an intervention and emailed the Assistant Directors of Nursing (ADON) to place an order for it. In the meantime, multiple types of interventions were trialled, but found ineffective. The SDM followed up with the home on a later date regarding the order for the intervention but due to communication gaps, the order had not yet been placed.

Sources: Resident's clinical records, interviews with and RN and ADON.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure when a resident exhibited altered skin integrity, a skin and wound assessment was completed. The resident presented with altered skin integrity on a specific date. An RN indicated that at the onset of any altered skin integrity, the Weekly Skin Assessment should be completed. This assessment tool was not completed for the resident's altered skin integrity until a later date.

Sources: Resident's clinical records, interview with an RN.

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times. A housekeeping cart was observed unattended in a

resident home area (RHA) with cleaning supplies inside an unlocked compartment. The housekeeper (HSK) indicated they did not receive a key to keep the cart locked. In another part of the RHA, the same HSK showed a storage room where some cleaning supplies were located. This room was also not locked despite a sign posted on the door indicating it should be kept locked. The HSK acknowledged the housekeeping cart and storage room should have been locked as per the home's policy and for resident safety.

Sources: Observations, interview with a HSK.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). The IPAC Standard for Long-Term Care Homes, Additional Requirement 11.6, indicated long-term care homes (LTCHs) must post signage at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring, as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual. The home posted this signage only at the main entrance.

Sources: Observations.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND

CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift the symptoms indicating the presence of infection in a resident were recorded. The resident presented with symptoms of an infection on a specific date and was placed on additional precautions (AP). An RN confirmed that during the time period when the resident remained on AP, their symptoms of infection were not documented on multiple shifts.

Sources: Resident's clinical records, Outbreak line list, interview with an RN.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #006 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 of an outbreak of a disease of public health significance or communicable disease.

1)The home documented multiple residents in a specific RHA presented with symptoms of infection within a specified period of time, which met the home's definition for a type of disease outbreak. The Director was not notified of this disease outbreak until a later date.

Sources: Outbreak line list, policy "Outbreak identification and reporting", CI report.

2)The home documented multiple residents in a specific RHA presented with symptoms of infection within a specified period of time, which met the home's definition for a type of disease outbreak. The Director was not notified of this disease outbreak until a later date.

Sources: Outbreak line list, policy "Outbreak identification and reporting", CI report.

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide in-person education to the IPAC lead on the home's policy related to reporting requirements to Toronto Public Health (TPH).
a) Maintain a record of the education and training provided, including the content, date, signature of attendants, and the name of staff member(s) who provided the education.
2) Retain all records until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied.

Grounds
The licensee has failed to ensure an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act was followed.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the IPAC program were complied with. Specifically, the home’s policy indicated all suspected outbreaks required immediate reporting to TPH.

1) The home documented multiple residents in a specific RHA presented with symptoms of infection within a specified period of time, which met the home's definition of a type of disease outbreak. TPH was not notified of the disease outbreak until a later date, as confirmed by the Director of Nursing (DON). By this date, more residents were already infected.

Sources: Policy "Outbreak identification and reporting", outbreak line list, confirmed outbreak management checklist, interview with DON.

2) The home documented multiple residents in a specific RHA presented with

symptoms of infection within a specified period of time, which met the home's definition of a type of disease outbreak. TPH was not notified of the disease outbreak until a later date, as confirmed by a TPH Inspector. By this date, more residents were already infected.

Sources: Policy "Outbreak identification and reporting", outbreak line list, confirmed outbreak management checklist, email from a TPH Inspector.

This order must be complied with by May 6, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.