

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: June 10, 2025

Inspection Number: 2025-1512-0002

Inspection Type:

Critical Incident
Follow up

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): June 5, 6, 10, 2025

The following Follow-Up intake was inspected:

- Intake: #00143231 - Follow-up #001, related to Infection Prevention and Control (IPAC)

The following Critical Incident intake(s) were inspected:

- Intake: #00143660 and Intake: #00145870, both related to IPAC.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1512-0001 related to O. Reg. 246/22, s. 102 (11)
(a)

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

Infection Prevention and Control

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INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 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 ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1(f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that a staff member used the appropriate personal protective equipment (PPE) in accordance with additional precautions when they provided care to a resident.

Sources: Resident care observations, Additional Precautions signage and a resident's progress notes; and interviews with a staff member and other staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 102 (9)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

(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 a resident's symptoms indicating the presence of infection were monitored every shift and that immediate action was taken to reduce transmission and isolate the resident.

The resident exhibited symptoms of infection and their symptoms were not monitored for one shift, and they were not immediately placed on additional precautions, which was acknowledged by the Director of Nursing (DON).

Sources: Review of Toronto Public Health's (TPH) Outbreak Line List, a resident's clinical records; and interview with the DON.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

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The licensee has failed to ensure that a resident's symptoms indicating the presence of infection were monitored every shift, for one shift, when they were on additional precautions and was acknowledged by the DON.

Sources: Review of TPH's Outbreak Line List, a resident's progress notes and vitals; and interview with the DON.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #004 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 the home's disease outbreak which was declared by TPH. The DON acknowledged that the outbreak was reported to the Director two days later.

Sources: Review of Critical Incident (CI) report and interview with the DON.