Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 1, 2021	2021_631210_0015	011632-20, 023086-20	Critical Incident System

Licensee/Titulaire de permis

Better Living at Thompson House
1 Overland Drive Toronto ON M3C 2C3

Long-Term Care Home/Foyer de soins de longue durée

Better Living at Thompson House
1 Overland Drive North York ON M3C 2C3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 2021

During the course of the inspection the following Critical Incident System (CIS) intakes were inspected:
-Log #011632-20, related to falls prevention program,
-Log #023086-20, related to responsive behaviors and mandatory reporting.

The inspection was conducted concurrently with complaint inspection (log # 003292-20) and follow up on compliance order (log #001959-20) related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Personal Support Workers (PSWs) and Behavioural Support Ontario (BSO) program lead.

During the course of the inspection the inspector observed provisions of care, reviewed clinical records, and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to resident #004 had occurred was immediately reported to the Director.

On a specified date and time resident #004 was found on the floor, in front of resident #003's room, as reported by resident #005 to registered staff. Resident #004 sustained an injury, for which they were treated. Resident #003 and resident #004 had an altercation, and resident #004 ended up on the floor. Resident #004 was treated for a health issue after the incident and was reassessed for their health status.

The incident report was submitted to the Ministry of Long term Care (MLTC) six days after it happened.

Sources: the CIS report, clinical records, interview with the DOC and other staff. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident that has occurred or may occur was immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 6th day of April, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.