



**Ministry of Health and  
Long-Term Care**

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

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

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## Public Copy/Copie du public

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 9, 2015	2015_214146_0001	H-001561-14	Complaint

### Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD  
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

BILLINGS COURT MANOR  
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

BARBARA NAYKALYK-HUNT (146)

## Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 6, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator; Medical Director; registered staff; Personal Support Workers (PSW'S); hairdresser; residents and a family member.

The following Inspection Protocols were used during this inspection:



## Personal Support Services

During the course of this inspection, Non-Compliances were issued.

1 WN(s)  
0 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)

### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #001's medication administration record (MAR) was the tool used by registered staff to sign when they provided and removed a specific device twice daily. Registered staff confirmed that they provided the care to the resident but sometimes forgot to sign the MAR. Since October 19, 2014 there were 24 missed signatures up to and including December 31, 2014. The RAI coordinator confirmed that the documentation of the intervention was incomplete.

B) The nutrition/hydration intake record was the tool used to record residents' nutritional intake for all meals and snacks. Resident #001, assessed as a high nutritional risk resident, had missing documentation on the nutrition/hydration intake records. The months of September, October, November and December 2014 were observed to be missing documentation for: one lunch; four afternoon snacks; four suppers and four bedtime snacks. The RAI coordinator confirmed that the documentation of the resident's nutritional intake was incomplete.

C) PSW's recorded the care given to residents each eight hour shift on a resident flow sheet entitled "PSW Documentation Record". Between September 1, 2014 and December 31, 2014, resident #001's flow sheets had 16 shifts where no documentation of care was completed; that is, the flow sheets were blank for those shifts. The RAI coordinator confirmed that the care documentation was incomplete. [s. 30. (2)]



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**Issued on this 9th day of January, 2015**

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

**Original report signed by the inspector.**