Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 23, 2019	2019_556168_0021	017174-19	Critical Incident System

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

LISA VINK (168)

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): October 9, 10, 15 and 16, 2019.

Please note that this inspection was conducted with concurrent Complaint Inspection, Inspection Report 2019_ 556168_0020.

Please note that a Voluntary Plan of Correction (VPC) related to Ontario Regulation (O. Reg.) 79/10 section (s). 30(2) related to general requirements was identified in this inspection and has been issued in Inspection Report #2019_556168_0020.

Please note that this inspection was conducted related to log # 017174-19 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN) and personal support workers (PSW).

During the course of the inspection, the inspector reviewed clinical records including but not limited to: policies and procedures, incident reports, clinical health records and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #010 fell, they were assessed utilizing a post fall assessment that was a clinically appropriate assessment instrument, specifically designed for falls.

According to the progress notes resident #010 sustained a fall on an identified date in July 2019.
A review of the clinical record did not include a post fall assessment using a clinically appropriate assessment instrument.
Interview with RN #106 following a review of the clinical record including the progress notes, assessment tab and risk management in Point Click Care (PCC) confirmed that a post fall assessment was not conducted using a clinically appropriate assessment instrument for the fall.

On an identified date resident #010 was not assessed with a clinically appropriate assessment instrument, specifically designed for falls. [s. 49. (2)]

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.