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

Hamilton District
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Original Public Report

Report Issue Date: October 25, 2023	
Inspection Number: 2023-1422-0008	
Inspection Type: Complaint Critical Incident	
Licensee: Maryban Holdings Ltd.	
Long Term Care Home and City: Billings Court Manor, Burlington	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2023.10.26 14:25:47 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 10, 12-13, 16-19, and 23, 2023.

The following intake was inspected in this complaint inspection:

- Intake: #00098338 was related to concerns regarding resident care.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00096376 (CI 2938-000038-23) was related to falls prevention; and,
- Intake: #00096838 (CI 2938-000040-23) was related to alleged improper/incompetent treatment or care.

The following intake was completed in this inspection: Intake: #00097605 (CI 2938-000045-23) was related to falls prevention.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

A falls prevention device was observed in a resident's room. Its use was verified by a personal support worker (PSW) who the device was in place since the resident was transferred to that home area.

A review of the resident's care plan indicated that their substitute decision maker (SDM) requested to have it removed. Progress notes confirmed that discussion; however, no other progress notes regarding using the device were identified after that.

The resident's care plan and kardex included the use of a wheelchair with two staff for mobility. A PSW confirmed that only one staff member would be needed for transporting the resident in a wheelchair, but two staff were required for transferring into or out of the wheelchair. A registered practical nurse (RPN) acknowledged that the statements regarding mobility and the falls prevention device in the resident's care plan could be confusing for staff who were new or unfamiliar with the resident.

The RPN updated the care plan to reflect that the falls prevention device was to be used and that while two staff were required to transfer the resident into a wheelchair, only one was needed to push it.

Sources: resident's clinical records; observations; interviews with ADOC and other staff. [720920]

Date Remedy Implemented: October 12, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substituted decision makers (SDM) were given an

opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A resident began displaying signs and symptoms of illness. The registered nurse (RN) attempted to contact the resident's SDM/emergency contact #1 (SDM #1) but was unable to reach anyone and documented that they would try again later. The RN acknowledged that the did not attempt to reach SDM #1 a second time or call SDM/emergency contact #2 (SDM #2) during the rest of their shift. The RN also admitted that they were unaware that SDM #1 was away and that an alternate contact phone number was in the resident's electronic chart. That same day, an RPN documented calling SDM #1 and leaving a voice message, asking for them to call the nurse back. There was no documentation that the RPN attempted to contact SDM #2 or used the alternate contact number.

A few days later, an RPN stated that they were concerned regarding the resident's change in condition during their shift, but did not contact either SDM #1 or SDM #2.

The Administrator stated that the home's protocol was to contact the first emergency contact and then move to the next one if the first was not available. They acknowledged that this was not practiced consistently while the resident was experiencing an illness.

Failure to contact the resident's SDMs had the potential to deny them opportunity to participate fully in developing potential changes to the resident's plan of care related to the illness.

Sources: resident's clinical records, home's Investigation Notes; interviews with the Administrator, DOC and other staff. [720920]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The licensee has failed to comply with the system to monitor and evaluate a resident's food intake.

In accordance with Ontario Regulations 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, and must be complied with.

Specifically, staff did not comply with the home's policy Food and Fluid Intake Monitoring, which was

included in the licensee's Nutrition and Hydration Program.

Rationale and Summary
A review of a resident's typical eating pattern over a two month period indicated that they had a history of refusing meals. At one point, the resident's intake at meals began to decrease and meal refusals began to increase.

The home's policy of food intake monitoring specified that staff were to send a referral to the registered dietitian (RD) if a resident consumed 50% or less from all meals for three or more days, or has demonstrated a significant change in their normal food intake pattern.

For a six-week period food intake documentation showed an intake of 50% or less on 22 days. Based on the home's policy, a referral should have been sent to the RD on at least three separate occasions, but no dietary referrals related to food intake were identified in Point Click Care (PCC) during that time period.

Two PSWs stated that resident's food intake had declined during that time frame and had informed the home area's RPN. The RD was unaware of the change in the resident's intake, and acknowledged that a dietary referral should have been sent so they could investigate and determine an appropriate course of action.

Failure to inform the RD of the resident's change in intake may have resulted in the resident not receiving sufficient calories and/or nutrients.

Sources: resident's clinical records, Food and Fluid Intake Monitoring policy (RC-18-01-01, March 2023); interviews with the RD and other staff. [720920]

WRITTEN NOTIFICATION: Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
The home utilized Point Click Care (PCC) for their electronic medical record keeping for all residents.

A resident began displaying signs and symptoms of an illness. The home's physician was contacted and ordered medical diagnostics. The order also included directions to send the resident to the hospital if their condition worsened, if the resident was agreeable. At that time, the resident was adamant that they did not want to go to the hospital and refused to be transferred multiple times, which was fully documented in PCC.

The following day, the resident continued to wait at the home for mobile diagnostic and documentation showed that they continued to refuse transfer to the hospital.

An RPN stated that during their shift, the resident said if they had to go to the hospital, it was okay, but not until the next morning. The RPN added that the resident did not want their family contacted and bothered because they were away. However, the information in PCC did not corroborate the RPN's statement. Only the phrase that if the resident had to go to the hospital, it's okay was documented. No other documentation completed after the original progress note contained any of the additional information RPN alleged the resident had said.

An RN explained that any conversation with the resident should have been fully documented. The Director of Care (DOC) acknowledged that the resident's statement as it was documented in PCC could have been considered as consent. Their expectation was that any additional pertinent information from the resident would have been included in the documentation as it may have impacted the staff's course of action regarding the resident's eventual transfer to the hospital.

Failure to fully document the residents wishes and/or intent may have resulted in the nursing staff being unaware that the resident may have been willing to be transferred earlier, possibly delaying the transfer to hospital and possible treatment.

Sources: resident's clinical records; interviews with DOC and other staff. [720920]