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

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Original Public Report

Report Issue Date: November 27, 2024
Inspection Number: 2024-1422-0005
Inspection Type: Complaint Critical Incident
Licensee: Maryban Holdings Ltd.
Long Term Care Home and City: Billings Court Manor, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-8, 12-14, 2024

The following intake(s) were inspected:

- Intake: #00128153 - Critical Incident (CI) - Unexpected death of a resident.
- Intake: #00128166 - Complaint with concerns regarding plan of care, transferring and positioning techniques, falls prevention and management.
- Intake: #00130142 - CI - Unexpected death of resident.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident, specific to having registered staff feed the resident to reduce the risk of an acute medical emergency.

Rationale and Summary:

A resident passed away on a date in 2024, with an acute medical emergency noted as the cause of death.

A registered staff provided instruction that only registered staff were to feed the resident based on their assessment of the resident's nutritional risk. This was acknowledged by another registered staff, who further reported the importance of registered nursing staff in feeding as they would be able to detect signs and symptoms of intolerance at meal time to reduce the risk of the acute medical emergency.

There were no orders written in the resident's plan of care that provided direction for registered staff to feed resident. Non-registered staff continued to feed the resident until the date of death.

When the plan of care lacked direction for registered staff to feed the resident, the

resident received feeding support from non-registered staff, which may have increased their risk of an acute medical emergency.

Sources: Interviews with staff, resident's clinical records, referral to multidisciplinary team, 24 hour unit report, the home's investigation notes. [000762]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure the written plan of care for a resident's advance care directives set out clear direction to staff and others who provided direct care to the resident.

Rationale and Summary
Admission care conference records indicated a resident's advance care directive was extensive care with cardiopulmonary resuscitation (CPR) to be administered for witnessed cardiac arrest. The advance care directive order in the resident's record and template for the advance care directives form described the extensive care level of support as follows:

- Transfer to acute care hospital if deemed necessary by the attending physician
- Emergency surgery, if deemed appropriate by the attending physician
- Admit to intensive care unit (ICU) if needed. The acute care hospital has the final control over the admission to the ICU.

- Life support systems including CPR, respirator, feeding tube and intravenous as deemed necessary by the attending physician
- Antibiotics and other medication as required

Two registered staff recognized extensive care as the level of support where CPR was to be initiated when indicated; however, they were unable to decipher which components of the above description were relevant to the long-term care (LTC) setting. A member of the management team acknowledged that the description of extensive care level of support, specifically where life support systems were outlined, was reflective of interventions to be considered in an acute care setting. They confirmed that the description did not provide clear direction to staff regarding initiation of CPR in a LTC setting and that revisions to the level of support descriptions would be discussed with the LTCH management team.

Failure for resident advance care directives to provide clear direction to staff in a LTC setting poses a risk of confusion, which may delay actions taken to respond to a resident during an acute medical emergency.

Sources: A resident's progress notes and orders, advance care directives form, interviews with staff. [740735]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
The licensee failed to ensure the provision of care set out in a resident's plan of care was documented.

Rationale and Summary

On a date in 2024, a resident experienced an acute medical emergency at the long-term care home (LTCH) and was pronounced deceased. Immediately prior to the medical episode, two staff members provided care to the resident, and did not document this care. A member of the home's management team, acknowledged the care provided was to be documented in Point-of-Care (POC).

When staff did not document provision of care, the resident's contact with health care personnel was not accurately represented in their plan of care.

Sources: Resident's clinical record, critical incident system, interviews with staff. [740735]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective.

Rationale and Summary:

A resident had specific interventions in place to promote nutritional adequacy.

Resident's condition was declining, as they were approaching end of life.

Two registered staff acknowledged their assessments indicated the interventions were not well accepted or effective and confirmed the plan of care should have been revised to remove these interventions.

Lack of reviewing and revising the care plan to eliminate the interventions that were not effective may have led to an inconsistent approach to feeding the resident by staff.

Sources: Resident's clinical records, interviews with staff. [000762]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home's equipment, specifically the resident's assistive device, was maintained in a safe condition and in a good state of repair.

Rationale and Summary

On a date in 2023, a resident fell out of their assistive device, which resulted in an injury.

A registered staff confirmed the resident had a assistive device alarm in place and stated the alarm should sound when activated.

A staff member, who was present during the fall, confirmed they did not hear an alarm sound during the incident, and if they heard an alarm, it would have reduced the resident's risk of a fall as they would have attended to the resident.

A registered staff assessed the assistive device alarm and determined it sounded low even at the highest volume. The alarm was exchanged for a loud sounding alarm, which indicated the alarm was not in a good state of repair.

Failure to ensure that the resident's chair alarm was in good repair, put the resident at risk for harm or injury.

Sources: interviews with staff, resident's clinical records. [000762]

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home has failed to ensure the pain management program to identify pain in residents and manage pain was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), staff did not comply with the policy titled "Pain Identification and Management", last revised March 2023, which indicated residents are to be assessed "for a new pain using the comprehensive pain assessment (use Pain Assessment) in addition to the use of the PAINAD to assess all non-verbal and cognitively impaired residents".

Rationale and Summary

On a date in 2024, a resident experienced pain during an outing, which was reported to a registered staff member by the substitute decision maker.

The resident was provided with analgesics prn.

Pain assessments were not completed when the onset of pain was reported to the registered staff and should have been, which was acknowledged by two registered staff.

By not using a clinically appropriate assessment instrument that was specifically designed for pain, a detailed and standardized assessment to ensure a comprehensive analysis of the resident's pain was not captured.

Sources: The home's policy, titled: "Pain Identification and Management", last revised March 2023, staff interviews, resident's clinical records. [000762]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition was reported to the Director immediately.

Rationale and Summary

A resident was sent to the hospital for medical follow-up on a date in 2024 after complaints of pain. The resident received results that they have sustained an injury that could not be repaired.

There was a significant change in the resident's health status as their transfer status changed, an assistive device was implemented, and resident required increased administration of analgesics to manage pain.

The home submitted a complaint critical incident report on a date in 2024, that indicated a complaint was received by the home regarding the injury; however, there was no mention of a significant change and hospital transfer.

The home failed to submit a critical incident report to the director immediately to capture the injury, significant change, and hospital transfer.

Sources: Review of the Critical Incident Report (CIR), staff interviews, resident clinical records. [000762]

WRITTEN NOTIFICATION: Emergency Plans

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (13) (a)
Emergency plans
s. 268 (13) Every licensee of a long-term care home shall ensure that the emergency plans address recovery from an emergency, including,
(a) requiring that residents, their substitute decision-makers, if any, staff, volunteers, and students be debriefed after the emergency;

The licensee failed to ensure staff were debriefed following a medical emergency involving a resident.

Rationale and Summary

On a date in 2024, a resident experienced an acute medical emergency at the long-term care home (LTCH) and was pronounced deceased. Two staff were present at the time of the resident's change in status and two members of the home's registered staff responded to the medical emergency. A member of the management team confirmed that a debrief was not held with the involved staff members, as required by the home's medical emergency policy.

Failure to ensure staff were debriefed on the medical emergency led to a missed opportunity to review areas that went well and areas for improvement with the involved staff.

Sources: LTCH investigation records, policy #EP-05-01-01 "Code Blue - Medical Emergency" (revised January 2024), interviews with staff. [740735]

WRITTEN NOTIFICATION: Retention of Resident Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 276 (2)
Retention of resident records
s. 276 (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home.

The licensee failed to ensure a resident's record was kept at the home for at least the first year after they were discharged from the home.

Rationale and Summary

On a date in 2024, a resident experienced an acute medical emergency and was pronounced deceased. The resident's advance directives were to be maintained in the resident's physical chart. Registered staff confirmed that the advance directives were quickly located at the front of the resident's chart at the time of the emergency. At the time of inspection, a member of the home's management team could not locate the document to demonstrate that it had been retained as part of the resident's record.

Sources: A resident's record, policy #RC-04-01-01 "Advance Care Planning" (revised November 2023), interviews with staff. [740735]