Ontario

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 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
May 17, 2019	2019_543561_0007	001364-18, 003493-18, 004745-18, 006851-18, 006927-18, 014824-18, 015240-18, 018854-18, 027647-18, 033592-18	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

DARIA TRZOS (561), YULIYA FEDOTOVA (632)

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 27, 28, 29 and April 2, 3, 4, 5, 2019.

The following Critical Incident System (CIS) inspections were completed:
2938-000042-18, log #033592-18 - related to alleged staff to resident abuse,
2938-000026-18, log #027647-18 - related to alleged staff to resident abuse,
2938-000006-18, log #003493-18 - related to missing narcotic,
2938-000020-18, log #018854-18 - related to falls,
2938-000010-18, log #006851-18 - related to falls,
2938-000011-18, log #006927-18 - related to falls,
2938-000016-18, log #014824-18 - related to falls,
2938-000017-18, log #015240-18 - related to falls,
2938-000002-18, log #001364-18 - related to injury of unknown cause.

A Follow Up inspection with the log #004745-18, was conducted concurrently with this inspection.
A Complaint inspection log #003878-19, related to neglect and plan of care, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Manager of Resident Quality Care, Recreation Manager, Resident Assessment Instrument (RAI) Facilitator, Administrative Assistant, Nursing Department Assistant, Physiotherapist, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), recreation staff member, Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspector(s): observed provision of care, reviewed clinical records, investigation notes, reviewed relevant policies and procedures, education material, training records, program evaluations and reviewed camera footage.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2018_695156_0002	561

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act, 2007, includes a definition of different types of abuse.

A Critical Incident System (CIS) report was submitted to the Director by the home indicating that on an identified date a staff member observed PSW #110 abuse resident #008.
The investigation notes were reviewed and indicated that on an identified date a staff member witnessed PSW #110 abuse resident #008 and did not follow the plan of care related to the provision of care. The staff member called a Manager to tell them what they had just observed. The Manager arrived at the home and after interviewing the staff member witness, they immediately removed the PSW from work, and initiated the abuse and neglect protocol.

The identified staff member witness was interviewed by the LTCH Inspector #561 and confirmed the statement they made on the day of the incident. They had also stated that the resident's condition had deteriorated after the incident.

The Manager, who was notified of the incident by the witness, was interviewed and confirmed the events that the identified staff member had witnessed and reported. They had also stated that after the incident happened, the resident's condition declined.

The Administrator was interviewed and stated that the investigation concluded that PSW #110 abused resident #008 on the identified date.

The licensee failed to ensure that resident #008 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence.

The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On an identified date in 2018, the following compliance order (CO #002) from inspection number 2018_695156_0002 was made under LTCHA, s. 6 (10) was issued:

The licensee shall ensure that all residents that have an identified condition will be:
a) Assessed and identified for their risk level for developing an identified condition. This risk level will be documented in the resident's plan of care.
b) Each resident will be monitored, reassessed and the plan of care revised when the resident's care needs change or the resident shows signs or symptoms of the identified condition.
c) Resident's requiring monitoring of the identified condition will have clearly and accurately documented in the clinical record the time, value, action taken and registered staff signatures.
d) Registered staff will immediately notify the physician when a symptom of the identified condition was present and the value registers as "HI" when tested by an identified device.
e) The home shall educate all registered staff on the home's device manufacture booklet, and the significance of a "HI" reading.
f) The home shall include directions for the use and education, provided in the manufacturer's booklet, in the orientation for all newly hired registered staff members and will include examples of "HI" readings and the potential for harm to residents when staff fail to reassess residents with the identified condition.

The compliance date was March 30, 2018.

The licensee completed items (a), (b), (d), (e) and (f) in CO #002.
The licensee failed to complete item (c).
(c) Resident's requiring monitoring of the identified condition will have clearly and accurately documented in the clinical record the time, value, action taken and registered staff signatures.

A) Resident #005 had an identified diagnosis and had an order to assess resident on identified days.
The current written plan of care indicated that if there was no direction in case of episode of symptoms of the identified diagnosis to contact the physician as per the home's policy.
Resident #005 had an order in place to administer a medication for the identified condition.
Clinical records were reviewed and indicated that on an identified date in 2019, the resident was assessed and had a symptom of the identified diagnosis. Clinical records identified that there was no documentation indicating that an action was taken.

RPN #105 was interviewed and stated that initially when they assessed the resident the symptom was present however when they re-checked the resident it had changed. The RPN stated that they forgot to document the second assessment. The clinical records did not have the action documented.

The DOC and the Administrator were interviewed and stated that the RPN should have documented the assessment and the action taken.

B) Resident #009 had an identified diagnosis and had an order to assess the resisdent on identified days of the week. The resident had a physician order for a medication to be administered on daily basis for the identified condition. The written plan of care was reviewed and indicated that resident #009 was at risk for developing symptoms of the identified diagnosis and to contact the physician in case of the symptom being present.
Clinical records were reviewed and identified that the resident was assessed on an identified date in 2019 and showed a symptom of the identified condition and there was no evidence that an action was taken.

RPN #107 was interviewed and stated that they recalled assessing a resident that had a symptom of the identified condition; however, they did not recall the name of the resident. They also stated that they recalled calling the physician. They reviewed the records and

stated that they were not able to find any documentation related to the actions taken.

The DOC and the Administrator were interviewed and stated that if a resident had a symptom of the identified condition the registered staff were expected to notify the RN on the unit and call the physician for directions. This should have been documented in progress notes.

The licensee failed to comply with all the conditions specified in the order under the LTCHA. [s. 101. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A CIS report was submitted to the Director on an identified date in 2018, indicating that resident #004 sustained an injury on an identified date in 2018.

Based on progress notes review, the resident was sent to the hospital as a result of an injury. Resident #004 received treatment in the hospital and was sent back to the home. On an identified date in 2018, a physiotherapy referral was completed in the home. Interview with the Physiotherapist, indicated that, based on their lift and transfers recommendations, nursing staff conducted lift and transfers assessment for residents. The Physiotherapist's transfer consultation note indicated that the resident was transferred from a supine to sitting position with an identified assistance level. Sit to stand transfer: able with an identified level of assistance and verbal cueing.

Resident Assessment Protocol (RAP) assessment indicated that resident #004 received total assistance for all activities of daily living (ADLs) except for one identified ADL. Review of plan of care indicated in transfer interventions section that resident #004 weight bear as tolerated, required cueing with an identified assistance level.

Interview with PSW #115 and #116, interpreted the Physiotherapist's statement in transfer consultation note for resident #004 as sit-to-stand transfer was a transfer with an identified device. Physiotherapist stated that the resident did not require a device. The DOC indicated that transfer consultation note was not clear and confusing.

The licensee failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A CIS report was submitted to the Director on an identified date in 2018, indicating that resident #004 sustained an injury of unknown cause.

Based on progress notes review, the resident was sent to the hospital on an identified date in 2018, and had a change in their condition. Resident #004 returned back to the home after the treatment on an identified date in 2018.

Review of resident #004's Minimum Data Set (MDS) significant change in status assessment indicated that they had specified intervention for their ADLs with identified number of staff. Resident Assessment Protocol (RAP) assessment indicated that resident #004 received specified intervention for all ADLs except for feeding. Review of the written plan of care did not indicate that resident #004 required specified intervention.

Interview with RN #109 identified that the resident's written plan of care was to be updated, once MDS and RAP assessment were completed, which was acknowledged by DOC and the Manager of Resident Quality Care.

The licensee failed to ensure that the care set out in the plan of care for resident #004 was based on an assessment of the resident. [s. 6. (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The licensee failed to ensure that policies included in the organized program of nursing

services were complied with.

In accordance with the Long Term Care Homes Act (LTCHA)2007, c. 8, s. 8(1)(a) the licensee is required to ensure there is an organized program of Nursing Services for the home to meet the assessed needs of the resident and in accordance with O. Reg. 79/10, s.30 (1) 1, the licensee is required to ensure that each of the organized programs include policies, procedures and protocols.

A) The home's policy titled "Safe Resident Handling Policy", policy number CHS-01-20-06, revised October 2016, indicated that the staff were to report any unsafe acts, hazards, equipment problems, change in resident mobility status or any other untoward issue immediately to the supervisor or designate and report any incidents or near misses to the supervisor immediately.

A CIS report was submitted to the Director related to alleged staff to resident abuse on an identified date in 2018. The CIS report indicated that a transfer was provided to resident #007 with an identified level of assistance and the staff failed to follow the plan of care. A second PSW staff came to assist with the transfer and during the transfer the resident reported a change in condition. The investigation conducted by the home identified that the initial transfer was conducted unsafely and the PSWs should have stopped the transfer when the resident was verbalizing a change in condition. The PSWs did not report this incident to the registered staff.

PSW #103 was interviewed and stated that when they transferred resident #007 to the toilet with an identified device, the resident verbalized the change in condition. The transfer was not stopped and PSW #103 indicated that they should have reported the incident to the registered staff.

The Administrator and the DOC confirmed that the policy was not followed. (561)

The licensee failed to ensure that the home's "Safe Resident Handling" policy was complied with.

B) The home's policy titled "Safe Resident Handling", policy number CHS-01-20- 4, revised in October 2016, indicated that the team lead or the assigned staff member were to complete and document their assessment upon admission or within 24 hours using the mobility and transfer algorithms, which were included in Lift and Transfers assessment.

A CIS report was submitted to the Director on an identified date in 2018, indicating that resident #004 sustained an injury of unknown cause on an identified date in 2018. Resident #004 was admitted to the home on an identified date in 2017 and the Safety assessment for risk of falls identified them to be at an identified risk level. No documentation was identified in relation to the initial Lift and Transfers assessment. Review of resident #004's plan of care indicated in interventions section for transfer that resident #004 could weight bear as tolerated and required an identified level of assistance.

Interview with RN #109 indicated that the Lift and Transfers assessment was to be completed for residents by registered staff on admission and if there was a significant change in resident's status.

The DOC and the Manager of Resident Quality Care confirmed that the initial Lift and Transfers assessment was not completed for resident #004. (632)

The licensee failed to ensure that the home's "Safe Resident Handling" policy was complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg 79/10 s. 114 (2), the license was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The policy titled "Storage of Narcotics and Controlled Medications", policy number 6-5, reviewed April 2016, indicated that when narcotic or controlled medication is discontinued or an order changes, remove the count for the medication from the Narcotic/Controlled Ward Count sheet. The drug and the administration count sheet should be removed from the med cart and taken to the DOC/ADOC to be stored until drug destruction. For facilities with Narcotic Drop boxes two registered staff must record surplus medications in the narcotic log binder before placing them in the drop box.

A CIS report was submitted to the Director indicating a Controlled substance was identified as missing/unaccounted for.
The clinical records were reviewed and identified that on an identified date in 2018, the

physician had discontinued all medications for resident #006 as resident had a change in condition.
The CIS report indicated that registered staff #125, attempted to administer a medication that was earlier discontinued by the physician.

Registered staff #125 stated that the medication for this resident was still in the medication cart. Registered staff #124 was interviewed and stated that the physician had discontinued all medications for resident #006 during their shift. They recall removing all the medications that were in the blister pack; however, they were not able to recall if they had removed this identified medication from the medication cart.
Registered staff #124 stated that the process in the home was to remove all the discontinued medications from the medication cart and place the controlled substance in a separate bin awaiting destruction.

The Administrator and the DOC were interviewed and stated that when the physician had discontinued all the medications the registered staff failed to remove the controlled substance from the medication cart and discard them as per the policy.

The licensee failed to ensure that the "Storage of Narcotics and Controlled Medications" policy was complied with.

B) The home’s policy titled "Medications-Administration Of", policy number CN-M-01-1, revised September 2018, indicated that prior to administering medications the nurse is required to follow the eight rights when administering medication – right resident, right medication, right reason, right dose, right route, right frequency, right time, right site and to check physician's order on the MAR.

A CIS report was submitted which indicated that a Controlled substance was identified as missing/unaccounted for.
The investigation notes were reviewed and indicated that on an identified date in 2018, all medications for resident #006 were discontinued as they had a change in condition. Registered staff #125 attempted to administer as needed (PRN) medication to resident #006; however, they were stopped by a family member.
The physician orders were reviewed and identified that all medications were to be discontinued on the identified date. The Medication Administration Record (MAR) was reviewed and indicated that the medications discontinued, including the PRN, were crossed off as discontinued with the discontinuation date.

Registered staff #125 was interviewed and stated that they attempted to administer the identified medication to resident #006, but the family of the resident stopped them. The registered staff stated that they were aware that the resident had a change in condition and they did see that medications were discontinued; however, the PRN was not.

The Administrator and the DOC were interviewed and confirmed that the physician had discontinued the medications and the registered staff attempted to administer it, even though the medication was discontinued and crossed off on the MAR.

The licensee failed to ensure that the "Medication - Administration Of" policy was complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

A) A CIS report was submitted to the Director related to alleged abuse towards resident #007 on an identified date in 2018. The CIS report and the investigation notes indicated that a transfer was provided to resident #007 with an identified level of assistance and the resident reported a change in condition.

The written plan of care in place at the time of the incident was reviewed and stated that

resident #007 required an identified level of assistance for transfers.

PSW #103 was interviewed and stated that they did not provide a safe transfer to the resident on the identified date 2018, and failed to follow the plan of care related to transfers.

The home's policy titled "Safe Resident Handling Policy", policy number CHS-01-20-06, revised October 2016, indicated that an identified level of assistance was required when using identified devices for transfers.

The interview with the Administrator and the DOC, confirmed that staff used unsafe transferring and positioning devices when assisting resident #007.

B) A CIS report was submitted to the Director by the home on an identified date in 2018, indicating that a staff member witnessed PSW #110 abuse resident #008. The investigation notes were reviewed and indicated the staff member observed PSW #110 transfer resident #008 with an identified level of assistance. The investigation concluded that PSW #110 failed to follow the plan of care and used unsafe transfer.

The identified staff member witness was interviewed by the LTCH Inspector #561 and stated that on the identified date in 2018, they arrived at the home and observed PSW #110 abuse resident #008 and failed to follow the plan of care related to the provision of care.

The plan of care for resident #008, in effect at the time of the incident, was reviewed by the LTCH Inspector #561 and stated that resident required an identified level of assistance during transfer.

The Administrator was interviewed and stated that PSW #110 failed to follow the plan of care when they transferred the resident.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #007 and #008. [s. 36.]

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 the staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #005 had an identified diagnosis and had an order to be assessed for the identified condition on several days of the week. The resident also had the orders for identified medication, as needed (PRN) for the identified condition.
Clinical records were reviewed and indicated that on an identified date in 2019, the resident was assessed and they tested as having a symptom of the identified condition and there was no documentation indicating that an action was taken. The Electronic Medication Administration Record (EMAR) did not include that the PRN medication was administered for the identified condition.

RPN #105, who worked on the identified shift, was interviewed and stated that initially when they assessed the resident the symptom of the condition was present and then when they re-assessed them it had decreased. RPN stated that they forgot to document the assessment.

The DOC and the Administrator acknowledged that the PRN medication for the identified condition was not administered upon the initial assessment as per the physician order.

The licensee failed to ensure that the medication was administered to resident #005 in accordance with the directions for use specified by the physician. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The manufacturer's instruction for an identified device for transfers, indicated that once the resident was transferred to a toilet, the staff were to remove an attachment once the resident was seated.

A CIS report was submitted to the Director related to alleged staff to resident abuse on an identified date in 2018. The CIS report indicated that resident #007 was transferred to the toilet using an identified device by PSW #103.

During an interview with PSW #103, they stated that after they transferred the resident to the toilet, they left to complete another task and that the resident was left on the toilet attached to the device and the attachment was not removed.
The PSW failed to follow the manufacturer's instructions for the identified device.

The Administrator and the DOC were interviewed and acknowledged that the PSW should not have left the resident unattended with the attachment and failed to follow the manufacturer's instructions for the device. [s. 23.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was 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 (4): 3. A missing or unaccounted for controlled substance.

A CIS report was submitted to the Director on an identified date in 2018, related to a missing controlled substance.
The medication incident report was completed by the home related to this incident by the former DOC and the CIS report was submitted late to the Director by the former DOC. The former DOC was not available for an interview. The Administrator was interviewed and acknowledged that the CI was submitted late.

The licensee failed to ensure that the missing controlled substance was reported to the Director no later than one business day after the occurrence. [s. 107. (3) 3.]

2. The licensee failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to the hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee should, (b) inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4). O. Reg. 246/13, s. 9 (3).

A CIS report was submitted to the Director on an identified date in 2018, in relation to a fall of resident #001 resulting in injury. The CI report was submitted late.
The Administrator acknowledged that the CI, for resident #001's injury for which the resident was sent to the hospital, was submitted to the Director later than three business days after the occurrence of the incident.

The licensee failed to ensure that, where an incident occurred that caused an injury to resident #001 for which the resident was taken to the hospital, the Director was informed of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

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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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2019_543561_0007
Log No. / No de registre :	001364-18, 003493-18, 004745-18, 006851-18, 006927-18, 014824-18, 015240-18, 018854-18, 027647-18, 033592-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 17, 2019
Licensee / Titulaire de permis :	Maryban Holdings Ltd. 3700 Billings Court, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	Billings Court Manor 3700 Billings Court, BURLINGTON, ON, L7N-3N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ada DiFlavio

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA 2007.

The licensee shall prepare, submit and implement a plan to ensure that all residents residing in the home are protected from abuse by anyone.

In the plan the home shall demonstrate how they will ensure that:
1. Residents are protected from abuse by any staff in the home.
2. The plan of care related to provision of care for all residents in the home is being followed.

Please submit the written plan, quoting Inspection number 2019_543561_0007 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by May 31, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act, 2007, includes a definition of different types of abuse.

A Critical Incident System (CIS) report was submitted to the Director by the home indicating that on an identified date a staff member observed PSW #110 abuse resident #008.

The investigation notes were reviewed and indicated that on an identified date a staff member witnessed PSW #110 abuse resident #008 and did not follow the plan of care related to the provision of care. The staff member called a Manager to tell them what they had just observed. The Manager arrived at the home and after interviewing the staff member witness, they immediately removed the PSW from work, and initiated the abuse and neglect protocol.

The identified staff member witness was interviewed by the LTCH Inspector #561 and confirmed the statement they made on the day of the incident. They had also stated that the resident's condition had deteriorated after the incident.

The Manager, who was notified of the incident by the witness, was interviewed and confirmed the events that the identified staff member had witnessed and reported. They had also stated that after the incident happened, the resident's condition declined.
Resident #008 was no longer in the home.

The Administrator was interviewed and stated that the investigation concluded that PSW #110 abused resident #008 on the identified date.

The licensee failed to ensure that resident #008 was protected from abuse by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 4 history as they had multiple NC with a Voluntary Plan of Correction (VPC) to the current area of concern issued under this section on February 27, 2018 (2018_695156_0002) and on October 7, 2016 (2016_240506_0019). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be compliant with s. 101(3) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that the licensee is compliant with every order made under this Act, specifically to ensure that resident #005, and #009 and all other residents in the home requiring an identified monitoring shall have their level clearly and accurately documented in the clinical record with the time, value, action taken and registered staff signatures.

The plan must include, but is not limited, to the following:
1. How the home will ensure that resident #005, #009 and any other resident in the home requiring the identified monitoring will be monitored as per the plan of care.
2. Complete an audit to ensure that residents requiring the identified monitoring will have the levels checked as per the plan of care and the findings of the assessments shall be documented.
3. Who will be responsible for the audits and how often they will be completed.

Please submit the written plan, quoting log number #2010_543561_0007 and Inspector Daria Trzos by email to HamiltonSAO.moh@ontario.ca by May 31, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence.

The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On an identified date in 2018, the following compliance order (CO #002) from inspection number 2018_695156_0002 was made under LTCHA, s. 6 (10) was issued:

The licensee shall ensure that all residents that have an identified condition will be:
a) Assessed and identified for their risk level for developing an identified condition. This risk level will be documented in the resident's plan of care.
b) Each resident will be monitored, reassessed and the plan of care revised when the resident's care needs change or the resident shows signs or symptoms of the identified condition.
c) Resident's requiring monitoring of the identified condition will have clearly and accurately documented in the clinical record the time, value, action taken and registered staff signatures.
d) Registered staff will immediately notify the physician when a symptom of the identified condition was present and the value registers as "HI" when tested by an identified device.
e) The home shall educate all registered staff on the home's device manufacture booklet, and the significance of a "HI" reading.
f) The home shall include directions for the use and education, provided in the manufacturer's booklet, in the orientation for all newly hired registered staff members and will include examples of "HI" readings and the potential for harm to residents when staff fail to reassess residents with the identified condition.

The compliance date was March 30, 2018.

The licensee completed items (a), (b), (d), (e) and (f) in CO #002.
The licensee failed to complete item (c).
(c) Resident's requiring monitoring of the identified condition will have clearly and accurately documented in the clinical record the time, value, action taken

and registered staff signatures.

A) Resident #005 had an identified diagnosis and had an order to assess resident on identified days.
The current written plan of care indicated that if there was no direction in case of episode of symptoms of the identified diagnosis to contact the physician as per the home's policy. Resident #005 had an order in place to administer a medication for the identified condition.
Clinical records were reviewed and indicated that on an identified date in 2019, the resident was assessed and had a symptom of the identified diagnosis. Clinical records identified that there was no documentation indicating that an action was taken.

RPN #105 was interviewed and stated that initially when they assessed the resident the symptom was present however when they re-checked the resident it had changed. The RPN stated that they forgot to document the second assessment. The clinical records did not have the action documented.
The DOC and the Administrator were interviewed and stated that the RPN should have documented the assessment and the action taken.

B) Resident #009 had an identified diagnosis and had an order to assess the resident on identified days of the week. The resident had a physician order for a medication to be administered on daily basis for the identified condition. The written plan of care was reviewed and indicated that resident #009 was at risk for developing symptoms of the identified diagnosis and to contact the physician in case of the symptom being present. Clinical records were reviewed and identified that the resident was assessed on an identified date in 2019 and showed a symptom of the identified condition and there was no evidence that an action was taken.

RPN #107 was interviewed and stated that they recalled assessing a resident that had a symptom of the identified condition; however, they did not recall the name of the resident. They also stated that they recalled calling the physician. They reviewed the records and stated that they were not able to find any documentation related to the actions taken.

The DOC and the Administrator were interviewed and stated that if a resident

had a symptom of the identified condition the registered staff were expected to notify the RN on the unit and call the physician for directions. This should have been documented in progress notes.

The licensee failed to comply with all the conditions specified in the order under the LTCHA.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents. The scope of the issue was a level 2 as it related to two resident of three reviewed. The home had a level 2 compliance history as one or more unrelated NC were issued to the home in the last 36 months. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office