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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

## Amended Public Copy/Copie modifiée du public

| 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_0020 (A1) | 017663-19, 018909-19 | 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

Amended by LISA VINK (168) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

**To clarify the frequency of bathing.**

**Issued on this 23rd day of October, 2019 (A1)**

**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**

**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**
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Maryban Holdings Ltd.
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**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**

Amended by LISA VINK (168) - (A1)

### Amended 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): October 9, 10, 15 and 16, 2019.**

**Please note that this inspection was conducted concurrently with a Critical**

**Incident Inspection, with the inspection report number 2019_556168_0021.**

**Please note a Voluntary Plan of Correction (VPC) related to Ontario Regulation (O. Reg.) 79/10 section (s.) 30(2) related to general requirements identified in concurrent inspection 2019_556168_0021, was issued in this report.**

**Please note that this inspection was conducted related to:**

**Log 017663-19 related to falls prevention and management; and**

**Log 018909-19 related to falls prevention and management.**

**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), personal support workers (PSW), a physician, the pharmacist, the physiotherapist and residents.**

**During the course of the inspection, the inspector observed to provision of care and toured resident areas, reviewed 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:**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Medication**
**Personal Support Services**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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. 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 :**

(A1)
1. The licensee failed to ensure that any actions taken with respect to residents #010 and #012, under the falls prevention program, including interventions were documented.

O. Reg. 79/10, s. 48(1)1 requires a falls prevention and management program.

A. The plan of care, with a print date in August 2019, identified that resident #010 was at risk for falls and had an intervention in place which was initiated in March 2019.
RN #103, RPN #104 and PSW #102 each confirmed the use of the intervention at a specified time.
A review of the Resident Care Flow Sheet for approximately one week in August 2019, identified that the intervention was signed as "in place" on eight occasions only, of a possible 16 evening and night shifts.
Interview with PSW #102, #108 and #109 confirmed the expectation that when an intervention was in place, that the staff were to sign for the use on the flow sheet.
The DOC reviewed the flow sheet and confirmed the expectation that the intervention be signed for on the flow sheet, based on the forms reviewed.

B. According to the plan of care resident #012 was identified at risk and had interventions in place to assist in the management of falls.
The current plan of care noted the use of one intervention since November 2017 and a second intervention since May 2019.
A review of the Resident Care Flow Sheets, for the month of September 2019, did not consistently include the use of the identified interventions.
The second intervention was documented in place for a total of 45 shifts, which included documentation on the day, evening and night shifts.
The first intervention was documented as in use for a total of 73 shifts, which included documentation on the day, evening and night shifts.
The Flow Sheets also included documentation on 17 occasions that a third

intervention was in place.
A review of the clinical record did not include that the resident utilized the third intervention in September 2019.
Interview with RN #106 confirmed that the third intervention was not utilized by the resident.
The DOC reviewed the flow sheet and confirmed the expectation that the interventions be signed for on the flow sheet, based on the forms reviewed. [s. 30. (2)]

2. The licensee failed to ensure that any actions taken with respect to resident #011, under the nursing and personal support services program, including interventions were documented.

Long-Term Care Homes Act (LTCHA) 2007, s.8, requires an organized program of nursing and personal support services.

According to the plan of care resident #011 was scheduled for bathing twice a week.
A review of random Resident Care Flow Sheets, for approximately 23 weeks, from February 1, 2019 until August 31, 2019, identified that the intervention of bathing was not documented as offered, refused or accepted, on eight occasions of the possible 46 bathing opportunities.
Bathing was recorded as refused or accepted on only one occasion for identified weeks in February 2019, March 2019, April 2019, May 2019 and June 2019.
Interview with PSW #117 confirmed that the resident would refuse bathing at times.
Interview with RN #120 identified that in their opinion bathing was consistently provided to the resident; however, staff failed to document this intervention.
Interview with the DOC following a review of the Resident Care Flow Sheets confirmed that the intervention of bathing was not consistently recorded twice a week. [s. 30. (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 any actions taken with respect a resident, under a program, including interventions are documented, to be implemented voluntarily.***

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**WN #2: 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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #011 related to falls risk.

A review of the plan of care, with a print date in September 2019, noted that resident #011 was at risk for falls.
The plan of care included a focus statement which identified that they were at one risk of falls related to unsteady gait and their fracture risk score (FRS).
The plan of care also included a focus statement for limited physical mobility related to poor quality and safety of ambulation and noted that based on the Tinetti score the resident was at another risk for falls.
Interview with the DOC, following a review of the plan of care confirmed that the plan did not provide clear direction to staff regarding the residents risk of falls. [s. 6. (1) (c)]

**Issued on this 23rd day of October, 2019 (A1)**

**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**

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

## 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

## 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**

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by LISA VINK (168) - (A1) |
| **Inspection No. / No de l'inspection :** | 2019_556168_0020 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 017663-19, 018909-19 (A1) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 23, 2019(A1) |
| **Licensee / Titulaire de permis :** | Maryban Holdings Ltd.<br>3700 Billings Court, BURLINGTON, ON, L7N-3N6 |
| **LTC Home / Foyer de SLD :** | Billings Court Manor<br>3700 Billings Court, BURLINGTON, ON, L7N-3N6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Ada DiFlavio |

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**

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

## 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

## 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(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

## 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

## 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:

## 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

## 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

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

## 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

## 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

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  23rd  day of October, 2019 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by LISA VINK (168) - (A1)

Ontario

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

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

## Order(s) of the Inspector

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## 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

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