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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 14, 2022	
Inspection Number: 2022-1422-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Maryban Holdings Ltd.	
Long Term Care Home and City: Billings Court Manor, Burlington	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature** EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2022.12.19 15:37:10 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 22-25, 28-30, 2022.

The following intake(s) were inspected:

- Intake: #00003008, CIS #2938-000018-21, regarding an allegation of neglect.
- Intake: #00008139 regarding concerns related to a resident's death.

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

Prevention of Abuse and Neglect
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's care plan was revised when the resident's care needs changed.

The Registered Dietitian (RD) assessed the resident and assessed that the resident now required assistance during meals.

A nurse identified that the resident had declined and needed help with feeding.

The resident's care plan reflected that the resident only needed set up and supervision, and that they were able to feed themselves.

The RD identified that this was their care plan on admission and that the resident's care plan was not updated after they were assessed to need more assistance.

There was a risk that the resident's interventions related to eating assistance would not be followed as their care plan did not reflect the current plan of care.

The DOC acknowledged that the resident's care plan should have been updated to reflect the change.

Sources: A resident's progress notes, care plan; interviews with the RD, and DOC.

[748]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that any written complaint received concerning the care of a resident was immediately forwarded to the Director.

As per Ontario/Regulation 246/22, a licensee was required to immediately forward to the Director, any complaint that alleged harm or risk of harm, including, but not limited to physical harm, to one or more residents.

A resident was being assisted with care when they had a change in condition. The nurse provided an intervention, but the resident's condition declined.

The home received an email on three dates, indicating concerns related to the care of the resident pertaining to the change in condition.

The home's complaint log did not include this complaint from the family.

The DOC indicated that they did not believe the emails were complaints; rather the family seeking more information. Therefore, the complaints were not reported to the Director.

Sources: A resident's progress notes; email correspondence between the home and the POA; the home's complaint log; interview with the DOC.

[748]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 2.

The licensee has failed to ensure that the Director was immediately informed of a resident's sudden death.

The resident had a change in condition, and the nurse provided interventions. However, the resident continued to decline and passed away.

A discussion was held between the DOC and the doctor; and they did not believe at the time that this was a sudden and unexpected death.

However, the information that the doctor wrote in the resident's Medical Certificate of Death identified that the resident's death was sudden.

The Administrator acknowledged that this incident should have been reported to the Director.

Sources: A resident's progress notes, Medical Certificate of Death; interview with the DOC, and Administrator.

[748]

COMPLIANCE ORDER CO #001 Involvement of resident, etc.

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:

1) POAs are notified, and are able to participate in the implementation of the plan of care, when there is a change in a resident's dietary plan.
2) On-going quality monitoring activities are implemented to ensure that POAs are being notified of a change in a resident's dietary plan of care, for a minimum of one month, or until all staff are compliant with the process.
3) Records are kept of the quality monitoring activities, the results, and corrective actions taken, if any.

Grounds
The licensee has failed to ensure that a resident's Power of Attorney (POA) was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to their diet.

The Registered Dietitian (RD) changed a resident's diet, and there was no documentation of the POA being notified of the change in the resident's records.

The dietary manager identified that when there were changes made to a resident's diet, the RD would notify the POA, including discuss agreeance to the plan and alternatives, as needed.

The RD identified that if they notified the POA, it would be documented in the progress notes.

The resident's POA identified they were not aware that the resident's diet had changed, and if they had known they would not have brought in food items that the resident was no longer supposed to have. PSW #104 verified that the resident continued to have food items in their room until an identified date, whereby the resident had a change in condition.

There was a risk to the resident when their POA was not notified of their diet change and was not aware that they were bringing in food that no longer matched the resident's plan of care.

The DOC acknowledged that the POA was not given the opportunity to participate in the development and implementation of the resident's dietary plan of care.

Sources: A resident's progress notes, physicians orders; interviews with the dietary manager, registered dietitian, and the DOC.

[748]

This order must be complied with by December 28, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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