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

Original Public Report

Report Issue Date: August 8, 2024
Inspection Number: 2024-1422-0003
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 dates: June 14, 17-18, 24-28, 2024.

The following intakes were inspected:

- Critical Incident: #00112144/2938-000020-24 regarding abuse
- Complaint: #00114245 regarding falls, skin and wound, resident care and support services, laundry, transferring and positioning, medication management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident's right to proper care and services consistent with their needs was fully respected and promoted.

Rationale and Summary

A resident was left unattended during care that required a staff to be present.

Staff did not use the communication response call system when it was available.

Failure to provide the resident with proper care and services consistent with their needs had potential to increase risk of injury or harm to the resident.

Sources: observation of a resident and staff, interviews with staff.

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.

The licensee has failed to ensure that a resident's written plan of care provided clear direction to staff and others regarding a falls prevention strategy.

Rationale and Summary

A resident's care plan included a green falling star as a fall intervention.

A yellow falling star was observed in the resident's personal area.

Staff reported yellow and green star logos were used to communicate the same intervention; however, acknowledged the use of two colours was unclear.

Failure to ensure the written plan of care provided clear direction increased potential for misunderstanding the requirements of the intervention.

Sources: a resident's care plan, an observation, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other so that their assessments were integrated, consistent with and complemented each other.

Rationale and Summary

Observational skin assessments completed by personal support workers (PSW) staff noted a resident had areas of altered skin integrity.

A head-to-toe skin assessment and a Minimum Data Set (MDS) assessment completed by registered nursing staff during the same period noted the resident had no areas of altered skin integrity or skin problems.

Staff confirmed the assessments were inconsistent with each other.

Lack of collaboration between staff in the assessment of the resident increased risk for inadequate care.

Sources: a resident's Point of Care (POC) documentation, a resident's quarterly head to toe skin assessment, a resident's MDS assessment, interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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, (b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed regarding a personal care intervention.

Rationale and Summary

A resident's written care plan instructed that a specified intervention be provided, twice daily.

Orders showed the intervention was discontinued.

Staff reported a different intervention was in place and confirmed the plan of care was not revised when the care set out in the plan had changed.

Failure to ensure the plan of care was revised posed risk that the resident would not receive care consistent with their needs.

Sources: a resident's care plan and orders, interview with staff.

WRITTEN NOTIFICATION: Safe and Secure Home

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

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. 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.

The licensee has failed to ensure that staff used equipment in the home in accordance with manufacturers' instructions.

Rationale and Summary

An Instructions for Use Manual included directions on how to use a specified device.

A resident received assistance with care from staff using the device; however, staff failed to use the device in accordance with manufacturers' instructions.

Failure to use the device in accordance with instructions increased potential for risk of injury to the resident.

Sources: Instructions for Use Manual, interviews with staff.

WRITTEN NOTIFICATION: General Requirements for Programs

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (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.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary

Section 53 of Ontario Regulation (O. Reg) 246/22 requires the home to have an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

A resident had an area of altered skin integrity. Registered nursing staff were to complete weekly skin assessments of the area; however, one assessment was missing from the resident's clinical record.

Staff acknowledged the assessment was not documented.

Failure to ensure the assessment was documented increased potential for staff to have decreased knowledge of the resident's skin condition and whether the interventions in place to improve skin integrity were effective.

Sources: a resident's clinical record, interview with staff.

WRITTEN NOTIFICATION: Required Programs

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The licensee has failed to ensure that a resident received a skin assessment by an authorized person as described in subsection (2.1), using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they exhibited areas of altered skin integrity.

Rationale and Summary

A skin assessment completed for a resident on a specified date indicated they had an area of altered skin integrity that existed prior to the date of the assessment. There was no previous assessment of the area in their clinical record.

The resident had additional areas of altered skin integrity. Non-registered nursing staff reported the areas had been present for a specified period; however, registered nursing staff were not aware of them.

Staff confirmed assessments had not been completed for the identified areas using a clinically appropriate assessment tool.

Failure to ensure the resident received skin assessments when new areas of altered skin were first identified increased risk for worsening skin condition.

Sources: resident observation, a resident's skin assessment, interviews with staff.

WRITTEN NOTIFICATION: Required Programs

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that when a resident exhibited an area of altered skin integrity, the area of altered skin was reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Rationale and Summary

A skin assessment completed for a resident noted they had a new area of altered skin integrity.

After the initial assessment, no weekly assessments were completed for the specified area to note whether its condition remained the same, improved, deteriorated, or healed.

Staff confirmed the area was expected to be reassessed weekly, until healed.

Failure to reassess the area weekly increased risk of inadequate care of the resident.

Sources: a resident's weekly wound assessments, interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to ensure that internal reporting protocols for residents with responsive behaviours were developed and complied with in the home.

Rationale and Summary

The home's Responsive Behaviours policy directed staff to complete a risk management report on Point Click Care (PCC) when there was a physical or verbal aggression incident.

An altercation occurred between two residents.

A risk management report for the incident was not completed.

Staff acknowledged the report was not completed when it was required.

Sources: a resident's clinical record, a Responsive Behaviours policy, interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to their needs including assessments and interventions.

Rationale and Summary

An intervention was implemented to respond to a resident's responsive behaviours. The intervention required staff to complete documentation; however, the documentation could not be located.

Staff acknowledged the intervention should have been completed and maintained in the resident's chart.

Failing to complete the intervention posed a risk to ensuring the resident's behavioural support needs were met.

Sources: a resident's clinical record, interview with staff.

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations between and among residents, including identifying factors that could potentially trigger such altercations.

Specifically, staff failed to comply with their Responsive Behaviours policy, which was included in the home's responsive behaviour program.

Rationale and Summary

The home's Responsive Behaviours policy indicated that for residents with responsive behaviours, the care plan should identify the triggers to the behaviour(s).

A resident's care plan included one behavioural trigger; however, progress notes indicated they had multiple behavioural triggers.

Staff acknowledged that not all triggers were identified in the resident's care plan as required.

Failure to ensure that all triggers were identified in the care plan posed a risk of staff not being able to implement interventions to mitigate the resident's behaviours.

Sources: a resident's clinical record, Responsive Behaviours policy, staff interviews.

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.
The licensee has failed to ensure that steps were taken to minimize the risk of

altercations between and among residents, including identifying and implementing interventions.

Rationale and Summary

A resident had a history of responsive behaviours toward other residents.

Their care plan included a trigger and intervention to manage the behaviour.

During an observation, the intervention was not implemented.

Failing to implement the intervention posed a risk of an altercation between residents.

Sources: observations of a resident, interviews with staff, a resident's clinical record.

WRITTEN NOTIFICATION: Accommodation Services

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (ii)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

The licensee has failed to ensure that procedures were developed and implemented to ensure that a resident's clothing was labelled in a dignified manner within 48 hours of acquiring new clothing.

Rationale and Summary

The home's Personal Clothing policy instructed any new items of clothing be listed on inventory sheet and sent to laundry for labelling.

A form titled, "Resident Items to Be Labelled" was used to keep inventory of resident personal items. The form required names, signatures, and dates for those involved in receiving, labelling and returning personal items. Completed forms were to be filed in the resident's chart.

On two occasions, forms were not completed as required when new clothing items were brought into the home for a resident.

Failure to follow the policy increased potential for items to not be labelled and accounted for in a dignified manner.

Sources: Personal Clothing policy, Resident Items to Be Labelled form, staff interviews.

WRITTEN NOTIFICATION: Accommodation Services

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items.

The licensee has failed to ensure that their process to report and locate residents' lost clothing and personal items was implemented.

Rationale and Summary

The home received a report that a resident was missing clothing items.

The home's Missing Clothing Protocol, Lost and Found, directed a Missing Clothing Checklist be completed when a resident or family member reported a missing item. A copy of the completed checklist was to be maintained.

Staff reported the investigation of the resident's missing clothing occurred and the checklist form was completed; however, the home was unable to locate the checklist at the time of the inspection.

Sources: Missing Clothing Protocol, Lost and Found; interview with staff.

WRITTEN NOTIFICATION: Training and Orientation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received training on their Falls Prevention and Management program.

Rationale and Summary

The home's Falls Prevention and Management Program included a Falling Star/Leaf Flagging Guide. The purpose of the program was to identify residents at high risk for falls and inform staff and other team members interventions for reducing risk.

All staff members were to be educated on the program on hire and at minimum annually. Staff confirmed that not all staff who provided direct care received training on the Falling Star program.

Failure to ensure that all staff received training led to staff being unfamiliar with required components of the home's fall prevention and management program.

Sources: Falling Star/Leaf Flagging Guide, interviews with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

1. Perform weekly audits on a resident for four weeks to ensure specified fall interventions are in place as per their plan of care. Document the names of staff who completed each audit, dates and times the audits occurred, outcomes of the audits and any corrective actions taken based on audit results.

2. Prepare, submit, and implement a written plan on how the home will ensure that a specified fall intervention will be readily available in the home on a specified unit to meet the needs of residents who require the intervention. The home shall create and maintain a written record of the compliance plan and actions taken to respond to the plan. Please submit the written plan for achieving compliance for inspection # 2024_1422_0003 to hamiltondistrict.mltc@ontario.ca by August 9, 2024. Please ensure that the submitted written plan does not contain any Personal Information/Personal Health Information.

Grounds

1. The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan regarding fall interventions.

Rationale and Summary

Two residents were at risk for falls. Their plans of care directed use of specified fall intervention(s).

Both residents did not have their specified falls interventions in place when required.

Staff confirmed the interventions were not always in place. Staff noted one of the fall interventions were not always available for use on the home area.

Failure to ensure that interventions were in place had potential to increase risk of injury.

Sources: two residents' clinical records, a resident observation, interviews with staff.

2. The licensee has failed to ensure that the care set out in a resident's plan of care for skin and wound care was provided as specified in the plan.

Rationale and Summary

A resident's plan of care included specific instructions regarding the assessment and treatment of an area of altered skin.

On multiple occasions, the assessment and treatment of the area was not provided as per the directions set out in the plan of care.

Sources: a resident's clinical record, interview with staff.

This order must be complied with by September 20, 2024

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

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.