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

Public Report

Report Issue Date: May 7, 2025
Inspection Number: 2025-1422-0002
Inspection Type: 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: April 25, 29-May 2, 5-7, 2025

The following intakes were completed during this critical incident (CI) inspection:

- Intake #00140749/CI #2938-000008-25 related to infection prevention and control
- Intake #00141689/CI #2938-000012-25 related to falls prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 Additional Precautions section (e), under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023) the licensee has failed to ensure that correct signage indicating droplet/contact precautions was in place for a resident when it was required.

Signage was replaced with correct signage.

Sources: observation of resident room, observations of staff, interviews with staff, review of resident's progress notes.

Date Remedy Implemented: April 25, 2025

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure the bed alarm for a resident was implemented as required by their plan of care as a falls prevention and management intervention.

Sources: observation of resident's room, interviews with staff, review of resident's progress notes and plan of care.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure a resident's pain was assessed using a clinically appropriate instrument when they experienced new pain following a fall.

Sources: resident's progress notes and assessments, Pain Identification and Management policy (reviewed March 2025), interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

(2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection for a resident was monitored, and that immediate action was taken to isolate the resident and prevent the spread of infection to other residents when symptoms were observed.

Sources: review of resident's progress notes and electronic treatment administration record (eTAR), Home Specific Outbreak Plan, interview with staff.

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