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

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Public Report

Report Issue Date: September 10, 2025
Inspection Number: 2025-1422-0004
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 date(s): August 29, 2025 and September 2-5, 8-10, 2025.
The following intake(s) were inspected:
- Intake: #00152944 - Critical Incident (CI) related to Responsive Behaviours
- Intake: #00154430 - CI related to Prevention of Abuse and Neglect
- Intake: #00154750 - Complaint related to Residents' Rights and Choices, Reporting and Complaints, Resident Care, and Prevention of Abuse and Neglect.

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

Continence Care
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 revised when their level of assistance needed for safe transfers changed.

Sources: Record reviews; an interview.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure a resident was protected from abuse when they sustained an injury from force used by another resident.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident.

Sources: Record reviews; interviews.

WRITTEN NOTIFICATION: General requirements

NC #003 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.

A. The licensee has failed to ensure that actions taken with respect to a resident under the organized program of nursing services were documented.

A resident was assessed and found to require additional assistance with a specified care need; however, the assessment was not documented in accordance with the home's requirements.

Sources: Record reviews; interviews.

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

A staff member documented alterations in a resident's skin integrity, however, there was no further documentation to identify that an assessment was completed or a

reassessment of the area.

Sources: Record reviews; interviews.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that the resident monitoring and internal reporting protocols, referred to in subsection (1), were co-ordinated and implemented.

A resident monitoring protocol was not implemented for a resident on the date it was to be initiated.

Sources: Record reviews; interviews.