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**
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# Public Report

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| **Report Issue Date:** October 21, 2025 |
| **Inspection Number:** 2025-1422-0005 |
| **Inspection Type:**<br>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): October 14, 16-17, 20-21, 2025.
The following intake was inspected:
- Intake: #00158154 related to Prevention of Abuse and Neglect

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

## 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) 3.**
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:
3. Every resident has the right to have their participation in decision-making respected.

The licensee has failed to ensure that a resident's right to their participation in decision-making was respected when the home notified the resident's substitute decision maker (SDM) about a matter involving the resident when the home was aware the resident did not want their SDM to be informed.

**Sources:** Interviews; record review.

## WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 82 (2) 1.**
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.

The licensee has failed to ensure a staff received training on the Residents' Bill of Rights. The staff had been assigned training in the home's online learning management system but did not complete the training prior to or during the time they performed their duties in the home.

**Sources:** An interview.

## WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 82 (2) 3.**
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure a staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents.
The staff had been assigned training in the home's online learning management system but did not complete the training prior to or during the time they performed their duties in the home.

**Sources:** An interview.

## WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)**
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of resident tubs and shower chairs. The home's procedure required that brushes used to clean resident care equipment be stored in a sanitary manner off the floor; however, cleaning brushes in a shower room and tub room were not stored in accordance with the home's procedure.

**Sources:** An observation; a record review.

## WRITTEN NOTIFICATION: Hazardous substances

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 97**
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that a hazardous substance was kept inaccessible to residents at all times. A disinfectant cleaner was found on the floor in a tub room. The product was noted as poisonous, corrosive to eyes, a skin irritant and was to be stored in a closed container and locked up when not in use. The container did not have a lid on it and the door to the tub room was open, which left the substance accessible to residents.

**Sources:** An observation; a record review.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 5.3 Cleaning and Disinfection section (h), under the IPAC Standard for Long-Term Care Homes (revised September 2023), the licensee did not ensure that the home's procedure for Cleaning and Disinfecting Personal Care Equipment was followed. Items dedicated for resident use were expected to be labelled with the resident's name and/or room number; however, unlabeled personal items, including hair brushes, a toothbrush, mouthwash, and a razor were found in common areas which included a tub room, shower room and shared washroom.

**Sources:** An observation; a record review.