Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton, ON L8P 4Y7

Telephone: 905-546-8294
Facsimilie: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Quest, 11ième étage
Hamilton, ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 10 & 13, 2010	2010-171-2938-09AUG143602 2010-173-2938-13Aug104817	Complaint – H-00003

Licensee/Titulaire

Maryban Holdings Ltd. 3700 Billings Court, Burlington ON L7N 3N6

Long-Term Care Home/Foyer de soins de longue durée

Billings Court Manor, 3700 Billings Court, Burlington ON L7N 3N6

Name of Inspector(s)/Nom de l'inspecteur(s)

Bernadette Susnik – LTC Homes Inspector – Environmental Health #120
Elisa Wilson – LTC Homes Inspector – Dietary #171
Lesa Wulff – LTC Homes Inspector – Nursing # 173

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to food quality, housekeeping services and medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Services Manager, Food Service Manager, cook, residents, registered staff, personal support workers and several assistant Directors of Care.

During the course of the inspection, the inspectors conducted a walk through of the dining areas, serveries and common resident areas, resident rooms and washrooms, reviewed resident records and various other documents.

The following Inspection Protocols were used during this inspection:

Food Quality
Accommodation Services – Housekeeping
Medication Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

WN#1: The Licensee has failed to comply with: O. Reg 79/10, s.72(2)(g)

The food production system must, at a minimum, provide for, documentation on the production sheet of any menu substitutions.

Findings:

1. Menu substitutions were reviewed during this inspection with the food service manager. During the review it was noted that menu item substitutions have not been documented on the production sheets.

Inspector ID#:	171

WN#2: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(a)

Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary.

Findings:

1. Over 50% of the resident bedrooms in the Kent home area were noted to have very dusty wardrobe tops and overbed lights.
2. Dead insects inside bedroom and washroom light covers and cobwebs and dead insects between walls and wardrobes were observed in 30% of the resident rooms in the Kent home area and 10% had visible matter on the walls or doors.
3. Some of the resident-owned and home-owned furnishings (chairs/sofas) were noted to be soiled.
4. Common rooms such as the Nook and Granny room, parlor room and the community room in the Kent home area were observed to have accumulated dead insects and cobwebs in corners, behind furnishings and doors.
5. All 5 dining rooms were noted to have visible matter splattered onto wall/wood surfaces in and around the servery serving counter and the floor surfaces along the serving counters were noted to have a build up of residue.
6. Carpets in the elevator area on both 2nd and 3rd floors were noted to be heavily stained.

Inspector ID#:	120

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#3: The Licensee has failed to comply with: O.Reg. 79/10, s.8(1)(b)

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Findings:

1. The home's in - house policy for medication administration - Policy # CN-M-01-1 (not dated) states to administer oral medication and remain with resident while he/she takes the medication. (Never leave a drug with a resident). Pharmacy (Smart meds pharmacy group) policy #3-6 last updated 09/07 states: Check the identity of the resident before giving the medication, and remain with the resident until the medication is given.
2. An identified resident's medications along with a single dose of laxative in open plastic cup were left in front of the resident during the lunch meal service in Wedgwood dining room on August 13, 2010. Nurse returned to the table in approximately 5 minutes to assist resident as she had made no attempt to take the medications on her own. This resident was sitting with three other table mates who had access to these medications if they chose to pick them up.
3. An identified resident was given medication crushed into 2 cal supplement during the lunch meal service in Bristol House home area on August 13, 2010. The supplement with the crushed medication was left at the table with the resident to consume without registered staff remaining with the resident to ensure medication was taken.
4. An identified resident was given a medication cup with pills in it and a glass of water when seated outside the nurse's station in Ainsley home area at 11:18 am on August 13, 2010. The registered staff member did not stay with the resident to ensure that medication was taken. A PSW approached the registered staff member approximately 5 minutes later and informed the registered staff member that the resident was struggling with her medications and required apple sauce. The registered staff member then proceeded to take the resident apple sauce in a cup and stayed with the resident while she took the remainder of her medication.
5. Empty medication cups were noted beside at least 4 residents in Wedgwood dining room during the lunch meal service upon initial entrance. Registered staff member was not in sight but returned approximately 6 minutes later to continue medication pass.

Inspector ID#:	173

WN#4: The Licensee has failed to comply with: O.Reg. 79/10, s.131(3)

Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Findings:

1. An identified resident's medication was crushed into applesauce by the registered staff member during the lunch meal service in Bristol House home area on August 13, 2010. The staff member left this medication with a second person who was seated with the resident and feeding her the lunch meal. The person

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

feeding the resident was not a staff member who worked at the home. This person proceeded to administer the crushed medication to the resident without observation or supervision from the registered staff member who left the medication.

2. During an interview with the Administrator and Assistant Director of care, it was stated that this resident was resistive with taking medications and would comply much better if medication was given by the person as observed. This information was not found on the plan of care for this resident. Specific instructions related to obligations/responsibilities of the registered staff member when a secondary person is to administer medications due to behaviors was not found in the homes policy and procedures.

Inspector ID#:	173

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Nov 29/10
Title: **Date:**	**Date of Report (if different from date(s) of inspection).**