Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the *Long-Term Care Homes Act, 2007*

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 18, 2020 | 2020_803748_0003 | 001313-20, 001472-20 | Critical Incident System |

### Licensee/Titulaire de permis

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 ou des inspecteurs

EMMY HARTMANN (748)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 20, 21, 22, 25, 26, 27, 28, June 1, 2, 2020, as an off-site inspection.**

**Log #001472-20, Critical Incident System (CIS) #2938-000004-20, was related to an injury following a fall incident.**

**Log #001313-20, CIS #2938-000003-20, was related to an injury with unknown cause.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RN), and registered practical nurses (RPN).**

**During the course of the inspection, the inspector also reviewed records, and policies.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order<br>AMP – Administrative Monetary Penalty | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités<br>AMP – Administrative Monetary Penalty |
| 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).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>AMP (s) may be issued under section 156.1 of the LTCHA | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.<br><br>AMP (s) may be issued under section 156.1 of the LTCHA |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (7).**

**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,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The home failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

Log #001472-20, CIS #2938-000004-20, an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was reported to the Ministry of Long Term Care (MLTC).

A review of resident #001's progress notes on an identified date, indicated that the resident had a fall incident.

During a review of resident #001's quarterly Risk Assessment for Falls on Point Click Care (PCC), completed on an identified date, it indicated that the resident was high risk for falls.

During a review of resident #001's written plan of care for falls, one of the interventions listed was for staff to ensure a certain intervention was in place.

During an interview with RPN #103, they identified that they were the nurse that responded to resident #001's fall on an identified date. They indicated that resident #001 did not have the appropriate intervention on.

During an interview with DOC #101, they identified that the resident's inappropriate intervention caused the resident to fall.

2. The home failed to ensure that resident #001 and resident #002 were reassessed and their plan of care reviewed and revised when their care needs changed or care set out in the plan was no longer necessary.

A: Log #001472-20, CIS #2938-000004-20, an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was reported to the MLTC. The CIS identified that resident #001 had an a diagnostic test completed on an identified date, following ongoing pain issues, which staff attributed to the resident's fall. The diagnostic test result confirmed that the resident had an injury and the resident was subsequently sent to the hospital.

A review of resident #001's clinical records, identified that the resident fell on an identified date and time. The note indicated that the resident fell and that they had pain, as a result. A post-fall huddle was conducted on an identified date, indicating that the resident did not have any injuries related to the fall, and that the doctor, POA, and management were notified of the incident.

Resident #001's written plan of care that was in place at the time of their fall, identified that they only required supervision for mobility.

A review of resident #001's progress notes, documented several days after the fall, on an identified date, indicated that the resident was in a mobility device, and that the resident had difficulty sitting still, and was attempting to get out of the mobility device. Progress notes also indicated that resident #001 had a change in mobility status due to pain.

During an interview with RPN #103, they identified that they were the nurse that responded to resident #001's fall, and that prior to the fall, the resident ambulated on their own without an assistive device. They verified that after the fall, the resident had difficulty ambulating due to pain and was using a mobility device, for several days after they fell. They also indicated that although resident #001 had chronic pain, the change in the resident's ambulation was new following the resident's recent fall incident. A review of the progress notes identified that a Physiotherapy (PT) referral was made on an identified date, and the PT went to see the resident on an identified date; however, the resident was noted to have refused the assessment and intervention.

The home's policy titled "Acute Changes in Resident Condition, dated June 2010" identified that when a resident has had a change in their condition, the Registered Staff

will assess and take vital signs; notify the physician attending the resident including having further assessment by a nurse practitioner arranged; document on the progress notes; and record all changes in the care plan.

Progress notes documented by the physician indicated that they assessed resident #001, that the resident had been experiencing pain for several days after their fall, and the resident was now mainly using a mobility device and had not ambulated due to pain. The note identified that the doctor ordered diagnostic testing to be completed to rule out an injury.

During an interview with DOC #101, they acknowledged that resident #001 had a change in condition several days after their fall; however, the resident was not reassessed by the health care team, the physician was not notified, and plan of care was not revised until several days later when an injury was identified requiring treatment.

B: Log #001313-20, CIS #2938-000003-20, an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was reported to the MLTC.

During a review of resident #002's progress notes, it identified that the resident first started to complain of new pain on an identified date and time, and they were given pain medication.

Progress notes documented on an identified date and time, by RPN #105 indicated that a PSW noted that the resident had signs and symptoms of a new injury, and it was endorsed to the next shift to follow up with the physician and assess.

Progress note documented over the next few days indicated that the resident had presented with an injury, and displayed subjective signs of pain during the assessment. The note identified that RPN #104 was instructed to give resident pain medication, but there was no mention of the doctor being notified.

After several days of pain, a progress note documented by RN #109, on an identified date, indicated that they saw resident #002 after it was reported to them that the resident had an injury. The note indicated that the resident had an injury and pain and that the doctor was called who advised for the resident to be sent to hospital.

The home's policy titled "Acute Changes in Resident Condition, dated June 2010"

identified that when a resident has had a change in their condition, the Registered Staff will assess and take vital signs; notify the physician attending the resident including having further assessment by a nurse practitioner arranged; document on the progress notes; and record all changes in the care plan.

During an interview with ADOC #102, they identified that the home investigated the events around this incident and that the resident was assessed by two RNs on an identified date, but the doctor was not called about the resident's change in condition. They identified that resident #002's plan of care was not reviewed and revised to reflect what needed to be done related to the resident's new ongoing pain and injury, until several days later when the resident was sent to hospital.

During an interview with DOC #101, they acknowledged that resident #002 presented with pain for several days, prior to the doctor being contacted. The DOC indicated that the staff failed to notify the physician of the change in condition and revise the plan of care.

3. The home failed to ensure that resident #004 was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Log #001472-20, CIS #2938-000004-20, an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was reported to the MLTC.

During a review of resident #004's Falls Assessments, it was identified that they had a fall on an identified date and time. The resident was noted to be found laying next to their mobility device, after a fellow resident had alerted staff that the resident was on the floor.

A review of resident #004's written plan of care identified that the resident was high risk for falls and that they had a fall prevention device in place, as one of the interventions.

During an interview with RPN #106, they identified that they were the nurse that responded to resident #004's fall on an identified date and time. They indicated that the resident was high risk for falls while in their mobility device, and that that the resident would frequently remove the fall prevention device. RPN #106 indicated that although the fall prevention device was in place, when the resident fell, it was not applied to them and it did not activate. RPN #106 indicated that to address the resident frequently

removing the fall prevention device; staff was supposed to check on the resident more frequently and place the resident by a specific location for close monitoring; however, they confirmed that this information was not added to the resident's written plan of care.

During an interview with DOC #101, they acknowledged that resident #004's plan of care should have been reviewed and revised to include that they needed to be monitored more frequently and that they were to be placed at a specific location for close monitoring, when the fall prevention device was noted to be an ineffective intervention.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 19th day of June, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c.8

**Ministère des Soins de longue durée**

**Order(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de sions de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | EMMY HARTMANN (748) |
| **Inspection No. / No de l'inspection :** | 2020_803748_0003 |
| **Log No. / Registre no:** | 001313-20, 001472-20 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 18, 2020 |
| **Licensee / Titulaire de permis :** | Maryban Holdings Ltd.<br>3700 Billings Court, BURLINGTON, ON, L7N-3N6 |
| **LTC Home / Foyer de SLD :** | Billings Court Manor<br>3700 Billings Court, BURLINGTON, ON, L7N-3N6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Ada DiFlavio |

To Maryban Holdings Ltd., you are hereby required to comply with the following order (s) by the date(s) set out below:

**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee must be compliant with section 6 (10) of the LTCHA.

Specifically the licensee must:

a. Ensure that resident #001, resident #002, and all other residents are reassessed when they have a change in condition, including changes in pain and mobility status after a fall or incident that causes injury.
b. Ensure that the physician is notified of any resident who has fallen or has an incident that causes injury with a change in pain and mobility status; and their plan of care is reviewed and revised.

**Grounds / Motifs :**

1. The home failed to ensure that resident #001 and resident #002 were reassessed and their plan of care reviewed and revised when their care needs changed or care set out in the plan was no longer necessary.

A: Log #001472-20, CIS #2938-000004-20, an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, was reported to the MLTC. The CIS identified that resident #001 had an a diagnostic test completed on an identified date, following ongoing pain issues, which staff attributed to the

resident's fall. The diagnostic test result confirmed that the resident had an injury and the resident was subsequently sent to the hospital.

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The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed.

The home had a level 3 compliance history of on-going non-compliance with this section of the Act that included:
-a Written Notification (WN) and Compliance Order (CO) issued February 27, 2018 (2018_695156_0002).
-Additionally, the LTCH has a history of other 3 WNs, and 2 Voluntary Plan of Corrections (VPC) to other subsections in the last 36 months.

(748)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 17, 2020

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 18th day of June, 2020**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Emmy Hartmann

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office