Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date July 6, 2022
Inspection Number 2022_1422_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Maryban Holdings Ltd.

Long-Term Care Home and City
Billings Court Manor, Burlington

Lead Inspector
Emmy Hartmann (748)

Additional Inspector(s)
Parminder Ghuman (706988)
Melody Gray (123)

Inspector Digital Signature
EmmyLou Hartmann
Digitally signed by EmmyLou Hartmann
Date: 2022.07.08 09:46:38 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25, 26, 27, 28, 29, May 2, 3, 4, 5, 6, 9, 10, 2022. May 4, 2022, was conducted as an offsite inspection.

The following intake(s) were inspected:

- Log #019294-21, CIS # 2938-000022-21 related to falls.
- Log #002580-21, CIS 2938-000004-21 related to missing or unaccounted for controlled substances.
- Log #007325-21, CIS 2938-000010-21 related to an allegation of resident to resident abuse.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA 2007 s.6(7)

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. The licensee failed to ensure that the care set out in the plan of care related to responsive behaviours was provided to a resident as specified in their plan.

On an identified date, two residents were involved in an altercation that resulted in no injury. The residents had a history of altercations.

The plan of care for one of the residents directed staff to provide an intervention on all three shifts. The home's calendar of PSW care provided to the resident indicated that the intervention was not provided on all days as per plan of care.

B. The licensee has failed to ensure that the care set out in the plan of care related to responsive behaviours was provided to a resident as specified in their plan.

Two residents had a history of responsive behaviours and required an intervention. On an identified date, the two residents were involved in an altercation which resulted in physical injury to one of the residents.

The plan of care for one of the residents directed staff to provide an intervention on all three shifts. The home's calendar of PSW care provided to the resident indicated, that the intervention was not provided on all days as per plan of care.

Sources: Interview with the DOC; the home's Calendar of PSW hours and the resident's health record including the care plan and progress notes.

[123]

WRITTEN NOTIFICATION [DRUG DESTRUCTION AND DISPOSAL]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 r.136(4) 5

The licensee has failed to ensure that when a drug that was to be destroyed was a controlled substance, that the reason for destruction was documented in the drug record.

In accordance with O. Reg. 79/10 r.8(1) b, the licensee was to ensure, as part of the medication management system, that a written policy was developed that provided for the destruction and disposal of medications, and that it must be complied with.

Specifically, the home did not comply with their Surplus and Discontinued Narcotic and Controlled Medications, which indicated that the reason for destruction was to be documented in the Log Record of Narcotics for Destruction form.

An incident of 20 number of missing controlled substances was reported to the MLTC in February 2021.

A review of the Log Record of Narcotics for Destruction form identified that there was no area to document the reason for destruction on the form at the time of the incident. The DOC identified that a reason for destruction column had been added on the form after the incident.

Sources: Home's Surplus and Discontinued Narcotic and Controlled Medications, last reviewed March 2020, and Log Record of Narcotics form; interview with DOC.
[748]

WRITTEN NOTIFICATION [REPORTS RE CRITICAL INCIDENTS]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.107 (3) (4)

The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A resident had a fall and sustained an injury for which they were transferred to hospital. The Charge Nurse received information that the resident would require be admitted to the hospital as they were requiring further interventions.
The Assistant Director of Care (ADOC) and the doctor were informed. According to the CIS report, the CIS was submitted three days after the fall incident.

The ADOC confirmed they failed to report the incident in a timely manner.

Sources: CIS # 2938-000022-21, Interview with ADOC and Charge Nurse.

[706988]

WRITTEN NOTIFICATION [SECURITY OF DRUG SUPPLY]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 r.139(1)

The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

During an observation in one of the home areas, the medication room was observed to be left unlocked. The medication cart in the medication room was also unlocked. The medication room was not being used as there was no staff in the area. The registered practical nurse (RPN) was observed exiting a resident's room down the hallway.

The RPN identified that the medication room was supposed to be locked at all times, and acknowledged that the medication room was left unlocked when it was not in use.

The DOC acknowledged that all areas where drugs were stored were to be kept locked at all times when not in use.

Sources: Observation; interviews with RPN, and DOC.

[748]

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT SYSTEM]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.114(2)

The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate destruction and disposal of all drugs used in the home.

The licensee reported 20 discontinued narcotics that were to be destructed and disposed were missing and could not be accounted for. The home's process for narcotic or controlled medication destruction entailed two registered staff confirming the amount of narcotic/ controlled substance to be destructed, documenting it on the Resident Narcotic/ Controlled Drug Count form, and wrapping the form around the narcotic or controlled substance and bringing them to the DOC's office where the narcotic drop box for destruction was kept. Once at the DOC office, two registered staff, one of which could be the DOC, would review the Resident Narcotic/ Controlled Drug form to confirm the amount of the narcotic/ controlled substance to be destructed, and document on the Log Record of Narcotics for Destruction form prior to dropping both the narcotic/ controlled substance and the Resident Narcotic/ Controlled Drug Count form, into the double locked narcotic drop box.

The home's Surplus and Discontinued Narcotic and Controlled Medication Policy identified that the DOC and the pharmacist on an agreed upon date would remove the surplus narcotics and controlled medications from the drop box for destruction. There would be a verification of the quantity recorded on the Log Record of Narcotics for Destruction form against the Resident's Narcotic/Controlled Drug Count form confirming the quantity. However, there was no mention of cross referencing if what was discontinued in the home areas matched the contents of the narcotic drop box.

During an observation of the home's narcotic drug destruction on an identified date, it was observed that the DOC and the pharmacist confirmed that the Resident Narcotic/ Controlled

Drug Count form, the quantity of narcotic/ controlled drug remaining, the Log Record of Narcotic for Destruction form, all matched. However, there was no reconciliation if what was removed from the home areas matched what was in the narcotic drop box.

The DOC and the consultant pharmacist verified that they did not reconcile the narcotic/ controlled substance for destruction in the narcotic drop box, with what was discontinued and removed from the home areas. There was a Narcotic Ward Count form in the home area which documented when the narcotic/ controlled substance was removed; however, they did not use this form to cross reference during the narcotic destruction process. They acknowledged that not reconciling was a gap in their process of drug destruction.

The DOC and pharmacist acknowledged that not confirming the amount of narcotic/ controlled medication removed from home areas for destruction matched with what was in the narcotic drop box, may not have ensured the accurate destruction of narcotics. They acknowledged that this step was not included in their current policy and that it needed to be added.

Sources: Observation of the home's narcotic drug destruction; home's Surplus and Discontinued Narcotic and Controlled Medications policy, last reviewed March 2020; interviews with RPN, RNs, consultant pharmacist, and DOC.

[748]

COMPLIANCE ORDER [CO#001] [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.102(2)(b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with Ontario Regulation 246/22 s.102(2)(b).

The home shall ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee shall:

1) Ensure that all residents in a specified home area receive support to perform hand hygiene prior to receiving their meals.
2) Complete a Hand Hygiene audit to ensure all residents receive support to perform hand hygiene prior to receiving their meals. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

3) Documentation of the audit is kept, including when the audit was completed, what the findings were, the corrective actions taken, and who completed the audit.

Grounds

According to the Infection Prevention and Control (IPAC) Standard section 10.4 (h) dated April 2022, the licensee shall ensure that the hand hygiene program in the home included policies and procedures, as a component of the overall IPAC program, as well as, support for residents to perform hand hygiene prior to receiving meals and snacks.

The home's hand hygiene policy identified that residents should be encouraged or assisted with hand hygiene before and after meals.

During an observation of residents in a home area, 22 residents were observed not being assisted with or offered hand hygiene prior to their lunch meal. The RPN identified that residents were supposed to be offered hand hygiene prior to entry into the dining room and acknowledged that they were not provided hand hygiene.

The DOC identified that staff encouraging or assisting residents with hand hygiene was an issue within the home.

There may have been an increased risk of spread of infection if hand hygiene was not being offered to residents during a pandemic of COVID-19.

Sources: Observation; IPAC Standard April 2022, the home's hand hygiene policy, last revised December 9, 2020; interview with RPN, and the DOC.

[748]

This order must be complied with by: July 29, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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

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