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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 5, 2023	
Inspection Number: 2023-1422-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: Maryban Holdings Ltd.	
Long Term Care Home and City: Billings Court Manor, Burlington	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature** Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.06.13 08:07:21 -04'00'
Additional Inspector(s) Stephanie Smith (740738)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-5, 2023, and May 8-11, 2023

The following intake(s) were inspected:

- Intake: #00020081 - for a Complaint related to concerns with plan of care and weight loss.
- Intake: #00085679 - for a Complaint related to concerns with alleged neglect, continence care, restraints, and diabetic management.
- Intake: #00003985 - for a Critical Incident (CI) related to alleged neglect.
- Intake: #00005458 - for a CI related to improper/incompetent treatment.
- Intake: #00019082 - for a CI related to falls prevention and management.

The following intake(s) were completed in this inspection: Intake: #00005982; Intake: #00013658, Intake: #00013766; and Intake: #00020945 were all related to falls prevention and management.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

The licensee failed to ensure a plan of care was based on an interdisciplinary assessment for a resident.

In accordance with O.Reg 246/22, s. 11(1)(b) the licensee was required to ensure that the home's Hyperglycemia Protocol was fully implemented and complied with. Specifically, to ensure residents with a high glucose level were reported and treated promptly.

Rationale and Summary

From specified dates in April 2023, a resident experienced elevated blood sugars and other symptoms. During the course of the specified dates, the resident had consecutive elevated blood sugar readings.

The home's Hyperglycemia Management Protocol, indicated that staff were to notify the homes' Registered Dietitian (RD) to assess food intake and treatment with reversible symptoms when a resident's blood sugar readings are from a specified unit measurement.

No RD referral or assessment was completed regarding the resident's elevated blood sugar readings.

Failure to ensure a resident's plan of care was based on interdisciplinary assessments of their blood sugar readings, increased their risk for adverse health complications.

Sources: A resident electronic medical record, Diabetes Management- Hyperglycemia Policy, CI, interviews with staff. **[740765]**

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every operational Minister's Directive that applied to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the Licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

Rationale and Summary

The COVID-19 Guidance: Long-Term Care Homes in Ontario (March 2023) requires the licensee to ensure that all staff wear a medical mask for the entire duration of their shift indoors and that homes must ensure that all staff comply with masking requirements at all times.

On a date in May 2023, a staff member was observed pulling down their mask to speak face to face to a resident. That same day, another staff member was observed pulling down their mask to speak face to face to a different resident. In both situations, the staff members were within two inches of each resident's face.

The Infection Prevention and Control (IPAC) Lead acknowledged that staff should wear a mask

at all times when in the home and when interacting with residents, unless in a designated break room.

Failure of staff to follow universal masking requirements, put the residents at increased risk of infection.

Sources: Observations, interview with IPAC Lead. **[740738]**

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident experienced a change in health condition from October 2021 to April 2022. The home's RD and nursing staff became aware of the change in condition in April 2022 and did not communicate the resident's condition to the physician. The home's physician documented and acknowledged that they were unaware of the change in health condition until a date in August 2022. The RD, physician, and nursing staff acknowledged that the physician should have been notified of the resident's change in health condition.

Failure to ensure that the home's RD, physician, and nursing staff collaborated with each other in the assessment of a resident led to risk of negative impact to the resident.

Sources: A resident's clinical records, interview with physician, RD, and other staff. **[740738]**

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident immediately reported this suspicion to the Director.

Rationale and Summary

On a date in August 2022, the Substitute Decision Maker (SDM) of a resident submitted a complaint to the home regarding neglect of the resident. The Administrator acknowledged receipt of the complaint on the same day.

A Critical Incident System (CIS) report was submitted to the Director the following day. No after-hour submission report was completed.

The ADOC acknowledged that reporting to the Director for alleged neglect was to be done immediately and that did not occur in this situation.

Sources: CIS and interview with ADOC. **[740765]**

WRITTEN NOTIFICATION: Protection From Certain Restraining

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

The licensee failed to ensure that a resident was not restrained, in any way, for the convenience of staff.

Rationale and Summary

A resident was found by their SDM tilted in their wheelchair with no foot rests and they were unable to get up or change their position. Staff had tilted their wheelchair to prevent them from transferring and falling.

No records indicated that the resident was assessed for the use of restraints or Personal Assistive Service Devices (PASD). No consent or physician orders were obtained or documentation to note that the resident required the tilt function on their wheelchair. The resident's plan of care did not indicate the use of the tilt feature. Three staff members acknowledged that the resident was being tilted in their wheelchair on a regular basis for positioning and to prevent the resident from transferring from their wheelchair.

Failure to ensure the resident was not restrained in any way increased their risk for harm.

Sources: A resident's electronic medical records, review of complaint intake, Least Restraint Policy, interviews with ADOC and staff. **[740765]**

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident required the assistance of two staff for transferring.

A staff member assisted a resident with a transfer, by themselves. The resident's SDM was present and witnessed the event. The ADOC acknowledged that the staff should have sought assistance from another staff member before completing the transfer.

Failure to ensure that staff used safe transferring techniques when assisting a resident put the resident's safety at risk.

Sources: A resident's care plan, interview with ADOC and Administrator, and the home's investigation notes. **[740738]**

WRITTEN NOTIFICATION: Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee failed to ensure an interdisciplinary medication management system provided safe medication management and optimized effective drug therapy outcomes for a resident.

Rationale and Summary

A resident was experiencing symptoms and a telephone physician order for medications was obtained for the treatment. The order was transcribed and administered to the resident ten hours later.

At the time of the incident, the home had an emergency drug box available which contained commonly prescribed medications, including the prescribed medication for the resident. A registered staff acknowledged they did not obtain the medications from the emergency drug box to begin treatment immediately.

The DOC and ADOC both stated the expectation was that an order be processed once it is received, and that medication can be obtained from the emergency drug box. Specifically, when the medications are ordered and available in the emergency drug box, they should be given immediately.

Failure to provide safe medication management did not optimize effective drug therapy outcomes for a resident.

Sources: A resident's electronic medical records, CIS, interviews with staff. **[740765]**

COMPLIANCE ORDER CO #001 Duty to Protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- Educate all PSWs on a specified home area on the Home's Prevention of Abuse and Neglect and Zero Tolerance policies.
- Educate all Registered Staff on the home's Height and Weight Monitoring policy, specifically their responsibility for measuring and documenting resident weights.
- Create and implement a contingency plan for ensuring resident's weights are measured monthly and as needed when weight monitoring equipment is not available. Retain records each time the plan is utilized for a period of six months.
- Retain records of the education provided, including the names of staff educated, date and time education was provided and by whom.

Grounds

A. The licensee has failed to protect a resident from verbal abuse.

Section 2 of Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Rationale and Summary

A resident received assistance with care from a staff member while the resident's SDM was present. The SDM alleged the staff engaged in verbal abuse toward the resident. The home's investigation notes substantiated the abuse.

Failure to protect a resident from verbal abuse put the resident at risk of negative impact.

Sources: Complaint letter, the home's investigation notes, interview with ADOC. **[740738]**

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of LTCHA.

B. The licensee has failed to ensure that a resident was protected from neglect.

Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

A resident experienced a change in health condition for six months. The resident's condition went undetected as the resident's health condition was not monitored monthly. The DOC acknowledged that it was the unit nurse's responsibility to ensure that the resident's condition was monitored and documented on a monthly basis. The home's RD and DOC cited multiple potential root causes and they were unable to identify why the resident's condition was not monitored monthly.

Failing to monitor a resident's health condition over a six month period demonstrated a pattern of inaction which jeopardized their health, safety, and well-being.

Sources: A resident's clinical record, interviews with RD, DOC and others. **[740738]**

This order must be complied with by June 16, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.