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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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 19, 2023

Inspection Number: 2023-1422-0006

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Maryban Holdings Ltd.

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

Lead Inspector	**Inspector Digital Signature**
Phyllis Hiltz-Bontje (129)	Phyllis Hiltz-bontje Digitally signed by Phyllis Hiltz-bontje Date: 2023.07.20 11:00:00 -04'00'

Additional Inspector(s)
Yvonne Walton (169)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 2, 5-8, 12-5, 21, 23, 26-30, 2023

The following intake(s) were inspected:

- Intake: #00007892 - [CI: 2938-000024-22] Improper/Incompetent treatment of a resident related administration of drug not prescribed to resident.
- Intake: #00021849 - Follow-up #: 1 -Inspection# 2023-1422-0004, O. Reg. 246/22 - s. 102 (8) CDD May 19, 2023.
- Intake: #00021850 - Follow-up #: 2, Inspection# 2023-1422-0004- O. Reg. 246/22 - s. 102 (2) (b) CDD May 19, 2023.
- Intake: #00088095 - IL-13255-HA - Complainant related to concerns regarding plan of care, abuse of a resident, food production and dining services, response to call bells/alarms, undercooked chicken and force feeding.
- Intake: #00089385 - Follow-up High Priority CO #001/2023-1422-0005, FLTCA, 2021 - s. 24 (1) Duty to Protect, CDD: June 16, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1422-0004 related to O. Reg. 246/22, s. 102 (8) inspected by Phyllis Hiltz-Bontje (129)

Order #002 from Inspection #2023-1422-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Phyllis Hiltz-Bontje (129)

Order #001 from Inspection #2023-1422-0005 related to FLTCA, 2021, s. 24 (1) inspected by Yvonne Walton (169)

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

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure a resident was reassessed, and the plan of care reviewed and revised when the residents' care needs changed, and the care set out in the plan was no longer necessary related to infection prevention and control measures.

Rationale and Summary

The residents' plan of care was reviewed, and it was noted the plan included a goal that an infection would be resolved, and staff were directed to use specific protocols when care was provided to the resident.

The Inspector observed that there was no longer a "Contact Precaution" sign posted on the resident's door and there were no Infection Prevention and Control (IPAC) supplies available for staff to use.

A Registered Nurse (RN) indicated the residents' infection had been declared resolved a month earlier and following a review of the residents' care plan they confirmed the residents' plan of care had not been revised to reflect the resident no longer required additional IPAC precautions.

The residents' electronic care plan confirmed the plan of care had been revised and no longer contained a care focus related to the infection. The electronic record indicate that the plan of care had been revised by a RN on June 5, 2023.

The failure of staff to update the residents' plan of care related to an infection that had been resolved posed no risk to the resident as the resident no longer required that specific care.

Sources: the residents' electronic care plan, observations of the residents' room area and an interview with a RN.
[129]

Date Remedy Implemented: June 5, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (1)

The licensee has failed to ensure information that is required to be posted in the home was posted in a conspicuous and easily accessible location.

Rational and Summary

The lobby area and the first-floor area were searched for the location of the posted Resident Council meeting minutes, and it was identified that the Resident Council meeting minutes and other information that is required to be posted in the home could not be found.

The Administrator directed the inspector to a large vestibule area between the exterior and interior front doors of the home, indicated the required postings were in a binder that lay on a small table on the far side of this space, and indicated the Resident Council meeting minutes were posted on the second and third floors of the home.

The information that is required to be posted in the home was not posted in a conspicuous location when it was noted that the postings binder was laying flat on a table in the large vestibule between the outer and inner glass doors of the home and although the postings binder was labeled "Required Posting per Fixing Long-Term Care Act" there was no signage to direct people to the binder. It was also observed that the binder could easily be missed because when entering the home, the exterior and interior doors open automatically, and people are prompted to walk straight ahead into the home.

Three residents who were active members of the Resident Council, confirmed they were unaware that the home was required to post specific information or where that information could be found in the home.

The required information was not easily accessible when it was noted that the binder did not include an index of what information was included in the binder or how to find specific information. Anyone inside the home would have to know the exit code for the front door to access the postings binder, and resident, family, and visitors on the first floor would have to be aware of the elevator code to review Resident Council meeting minutes posted on the second and third floors of the home.

The Administrator moved the location of the posted information to an area beside their office which was also located close to the reception desk, some required information was posted on the wall, the posting binder that included the additional information was placed upright on a sideboard under the information posted on the wall and an index of the information was posed on the wall. Resident Council meeting minutes were also now posted on the first floor of the home. The information that was required to be posted was now both in a conspicuous and easily accessible location.

The failure of the licensee to ensure the information that is required to be posted in the home was located in a conspicuous and easily accessible location posed no risk to residents.

Sources: Observations of the lobby and first floor of the home, the vestibule area between the exterior

and interior front doors and the “Required Posting per Fixing Long-Term Care Act” binder, interviews with three resident and the Administrator.
[129]

Date Remedy Implemented: June 29, 2023

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart that was secured and locked.

Rationale and Summary

On June 13, 2023, a medication cart was observed to be in a hallway across from the nursing station at the entrance to the Bristol home area dining room. It was noted that the medication cart was not locked, all drawers could be opened, a registered staff member was not in the vicinity and the medication cart was not being monitored by a registered staff member.

At the time of the observation it was noted that the area around the medication cart was busy as residents and staff were entering the dining room in preparation for lunch and the cart was easily accessible to staff visitors and others entering the home area.

A Registered Practical Nurse (RPN) emerged from a small room, verified they were the RPN working on the home area and had place the cart in the hallway. The RPN confirmed they had left the cart unlocked, unsecured and they indicated they were aware the cart was to be locked at all times when a nurse was not in attendance.

The failure of staff to ensure the medication cart was secured and locked increase the risk that a person could remove drugs from the cart and have access to residents' personal health information.

Sources: observations of the medication cart and the area around the cart and an interview with an RPN.
[129]

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