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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Original Public Report

Report Issue Date: September 14, 2023	
Inspection Number: 2023-1422-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Maryban Holdings Ltd.	
Long Term Care Home and City: Billings Court Manor, Burlington	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2023.09.18 13:29:14 -04'00'
Additional Inspector(s) Michelle Warrener (107)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16-18, 21-25, 28-31, and September 1, 2023.

The following intakes were completed in this complaint inspection:

- Intake #00093251 was related to medication administration; and
- Intake #00090502 was related to resident care, falls, safety and skin/wound care.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake # 00017914 (CI 2938-000002-23) was related to transferring,
- Intake # 00087733 (CI 2938-000023-23) was related to falls prevention; and
- Intake # 00093999 (CI 2938-000030-23) was related to abuse.

The following intakes were completed in this inspection: Intake #00087681, CI 2938-000022-23 and Intake #00092918, CI 2938-000028-23) were related to falls prevention.

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours
Safe and Secure Home
Skin and Wound Prevention and Management

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)
O. Reg. 246/22, s. 97

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

In a unit, next to the tub room, a bottle of Vestec 770 Pre-Spotter for protein stains dual enzyme system was stored in an unlocked cupboard under the sink. The door to the washroom was fully open and staff were not in the area. The bottle was labeled with a hazard symbol for WHIMIS Class D-2 hazardous material: materials causing other toxic effects and the label indicated to avoid contact with eyes and skin.

A personal support worker (PSW) came to the area and stated that the product was supposed to be kept in the locked room just outside the identified washroom. The PSW removed the bottle and placed it in the locked room.

The next day, the door to the same locked room was propped open with a lift. The same bottle of Vestec

770 was accessible in the room. The Laundry Manager identified that each home area was to have a bottle of the Vestec 770 and it was to be stored in the unlocked cupboard under the sink. The Manager acknowledged that the bottle of Vestec 770 had a hazard label and the bottle was immediately moved to a location that was inaccessible to residents. The Manager stated they would also assess and remedy all other home areas that may have been affected.

Failure to keep hazardous substances inaccessible to residents may result in handling or consuming the substance, causing injury to the resident.

Sources: observation; interview with the Laundry Manager and other staff. [107]

Date Remedy Implemented: September 1, 2023

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection were monitored for a resident.

Rationale and Summary
A resident had an infection with antibiotics initiated. The home's Director of Care (DOC) stated that staff were to monitor and document the resident's symptoms and condition daily in the progress notes. The DOC acknowledged that progress notes for two days did not include monitoring of the resident's symptoms or condition related to their infection.

Failure to monitor the symptoms of the resident's infection may have resulted in a delay in identifying a change in condition.

Sources: resident's progress notes, Physician orders, and laboratory results, interview with DOC. [107]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
The resident had a medical device and experienced a related change in condition. A registered practical nurse (RPN) confirmed that the change in condition was communicated to the day shift.

The day shift Registered Nurse (RN) confirmed that the change in condition on the night shift had been communicated to both them and the day shift RPN; however, documentation on the 24-hour shift report for the same date did not include that information. Another RPN stated that based on the change in condition over the night shift, staff should do an hourly assessment; however, there was no evidence that this was completed. The RN stated that they went to complete an assessment of the resident on the day shift; however, there were several other situations happening on the same unit within a short period of time and the assessment was not completed.

There was no follow up documentation or monitoring of the resident related their health condition for six hours prior to being sent to the hospital.

The Assistant Director of Care (ADOC) stated that the expectation for monitoring the resident after their change in condition would be to monitor every one to two hours based on the resident's health status and if it continued or worsened, staff should call the Physician. There was no evidence that the resident's Physician was called about their change in condition prior to the resident going to hospital.

Failure to reassess and monitor after a change in the resident's condition may have resulted in delay in treatment being provided.

Sources: resident's clinical and hospital records; interviews with the ADOC and other staff. [107]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
a) The resident's Physician ordered bloodwork to be completed in two weeks. The bloodwork was not completed as ordered. The Physician re-ordered the bloodwork two months later. The resident had an abnormal lab value that required treatment in an earlier lab report. That same lab value remained abnormal when tests were completed as per the Physician's re-order.

An RN confirmed with the lab that the orders for the bloodwork were not received by the lab and were not completed, despite two staff signatures confirming the Physician order at the home. The RN acknowledged the order for that bloodwork was missed and was completed two months later.

The delay in testing may have delayed treatment for the abnormal lab value.

b) An outpatient clinic had requested bloodwork for the resident. The bloodwork was completed; however, the home did not forward a copy of the results to the clinic as requested, which was confirmed by an RN.

When the resident's tests were not forwarded to the clinic, it may have resulted in decreased communication between providers.

Sources: the resident's clinical health record, including progress notes, Physician orders, laboratory results and interview with staff. [107]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse by anyone.

Section 2 (1) of the Ontario Regulation (O. Reg.) 246/22 defined physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A resident had a history of responsive behaviours towards staff and other residents. Their behaviours were unpredictable and, at times, not easily altered. Medication was prescribed to address the behaviours on an as needed (PRN) basis.

One afternoon, the resident exhibited an increase in responsive behaviours towards a staff member. The RPN could not immediately located the PRN medication; however, once located, it was administered to the resident and effective.

Approximately two hours later, a PSW heard screaming and found the resident in another resident's room. The resident was exhibiting responsive behaviours towards the other resident which resulted in an injury.

The administrator acknowledged that the resident's responsive behaviours could be unpredictable and resulted in injuring another resident.

Failure to protect a resident from abuse by anyone resulted in inquiries and had the potential for emotional distress.

Sources: two residents' clinical records; interviews with Administrator, ADOC and other staff. [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to comply with section (s.) 28 (1) 1 of the Fixing Long-Term Care Act (FLTCA) in that a person, who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm, failed to report the suspicion and information it was based upon immediately to the Director in accordance with the FLTCA.

Pursuant to FLTCA, s. 154 (3) the licensee was vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary
During an evening shift, a resident's substitute decision maker (SDM) asked an RN to assess the resident's injury and related pain. The RN's assessment made note of an injury and associated symptoms. The SDM stated that the injury and pain occurred during a transfer sometime between the previous day's afternoon/evening shift and the night shift.

A PSW explained that the incident occurred when the resident was transferred for bathing. Another PSW documented in Point of Care (POC) both a transfer and bathing had occurred for the resident on the evening shift. The home's Safe Resident Handling policy stated that staff are to report any incidents, accidents, and near misses to their supervisor immediately. The RPN supervising the unit on that shift was unaware of any incident that occurred during a transfer of the resident and acknowledged that there was no documentation in Point Click Care (PCC) of any such incident.

Critical Incident (CI) report #2938-000002-23 was submitted to the Ministry of Long-Term Care two days after the incident, and indicated that the after-hours line was not contacted. The administrator stated that they first became aware of the incident when the resident's SDM submitted a written complaint.

Failure to immediately notify the Director of improper or incompetent care of a resident that resulted in harm had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: resident's clinical notes, Safe Resident Handling Policy (January 2022), CI 2938-000002-23, Complaint Form and Response Letter; interviews with the Administrator and other staff. [720920]

WRITTEN NOTIFICATION: Policies and Records

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to comply with their nursing and personal care program policies to ensure that interventions to mitigate and manage risks related to hypoglycemia for a resident were implemented.

In accordance with Ontario Regulation, 246/22, s.11. (1) b, the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

Specifically, staff did not comply with the policy, "Diabetes Management-Hypoglycemia".

Rationale and Summary

The home's policy titled, "Diabetes Management-Hypoglycemia", defined hypoglycemia as a blood sugar less than 4.0 millimole per Litre (mmol/L) and directed staff to immediately treat all episodes of hypoglycemia (3.9 mmol/L or less). The policy also directed staff to retest the blood sugar levels after 15 minutes and re-treat if levels remained at 3.9 mmol/L or less. Staff were to document the treatment provided and the response to treatment in the progress notes.

A resident had blood sugar levels below 4.0 mmol/L on three separate days. Staff did not document that treatment was provided or that the blood sugar levels were re-tested. An RPN, who recorded the blood sugars, stated that treatment and re-testing for blood sugars between 3.0 and 4.0 mmol/L was not required. Staff did not follow the home's hypoglycemia policy.

On a fourth day, the resident's blood sugar was below 4.0 mmol/L. Treatment was provided; however, the blood sugar was not re-tested until two hours later, which was not consistent with the home's hypoglycemia policy. The ADOC confirmed that staff were to follow the home's hypoglycemia policy which indicated that staff should re-test the blood sugar after 15 minutes.

When the hypoglycemia policy was not followed, there was a risk of continued or more severe hypoglycemia for the resident.

Sources: interview with ADOC and other staff; resident's clinical health record including vitals and progress notes; policy "Diabetes Management -Hypoglycemia RC-24-01-02", last revised January 2022. [107]

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #008 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 using a mechanical lift.

Rationale and Summary
During an evening shift, a resident's substitute decision maker (SDM) asked an RN to assess the resident's injury and related pain. The RN's assessment made note of an injury and associated symptoms.

The SDM stated that the injury and pain occurred during a transfer sometime between the previous day's afternoon/evening shift and the night shift.

A PSW explained that the incident occurred when the resident was transferred for bathing. Another PSW documented in Point of Care (POC) both a transfer and bathing had occurred for the resident on the evening shift.

The home's investigation concluded that there were issues involving the manner and method of care and that staff involved would receive retraining regarding safe resident handling. The Administrator acknowledged that the staff did not use safe transferring techniques when transferring the resident.

Failure to transfer the resident using safe transferring techniques resulted in an injury and the resident experiencing pain and emotional distress.

Sources: resident's clinical notes, Safe Resident Handling Policy (January 2022), CI 2938-000002-23, Complaint Form and Response Letter; interviews with the Administrator and other staff. [720920]