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
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Original Public Report

Report Issue Date: February 7, 2024
Inspection Number: 2024-1422-0001
Inspection Type: Complaint Critical Incident
Licensee: Maryban Holdings Ltd.
Long Term Care Home and City: Billings Court Manor, Burlington

Lead Inspector	**Inspector Digital Signature**
Stephany Kulis (000766)	Stephany Kulis Digitally signed by Stephany Kulis Date: 2024.02.14 11:51:03 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25, 26, 29-31, 2024 and February 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00101675 - Critical Incident (CI) 2938-000049-23 - Related to infectious disease outbreak.
- Intake: #00102964 - CI 2938-000051-23 - Fall of resident resulting in injury.
- Intake: #00103665 -CI 2938-000052-23 - Fall of resident resulting in injury.
- Intake: #00105083 -CI- 2938-000056-23 - Related to infectious disease outbreak.
- Intake: #00105828 -Complainant has concerns regarding resident - plan of care and neglect.

- Intake: #00106982 -CI 2938-000005-24 - injury of resident, unknown etiology.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls 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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure the written plan of care provided clear directions to staff regarding which fall interventions for a resident were being used.

Rationale and Summary
According to a resident's plan of care, they had various fall interventions in place. Tasks for Personal Support Worker (PSW) staff were to monitor these interventions. On two separate occasions, the resident had one intervention in place but not the others. A PSW stated the other interventions were no longer in use, and that the plan of care provided unclear direction to staff. Registered Practical Nurse (RPN) stated the other interventions should have been discontinued when one of the interventions was initiated.

The plan of care was amended following the review of the resident's interventions, and are consistent with the current interventions in place.

Sources: Interviews with PSW, RPN; and resident clinical records [000766]

Date Remedy Implemented: February 2, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

A. The licensee failed to ensure the written plan of care provided clear directions to staff regarding specific feeding instructions for a resident were being used.

Rationale and Summary
Registered Dietician (RD) assessed a resident and documented specific feeding instructions. RD stated when assessment was conducted resident was not presenting at their baseline. RD stated specific instructions for the resident should have been included in the care plan to provide clear direction for staff.

Given the resident having periods not at their baseline it put them at risk for choking and possible aspiration.

Sources: Interviews with RD; and resident clinical records
[000766]

B. The licensee failed to ensure the written plan of care provided clear directions to staff regarding specific feeding instructions for a resident were being used.

Rationale and Summary
RD stated when diet orders became thickened fluids residents were to have medications crushed with a specified food, as a different food was too thin. Special care instructions continued to state medications crushed with a different food and should have been updated to crushed with the specified food to provide clear direction to registered staff how to give medications. RPN stated it was unclear to staff what to crush the resident's medications in.

Given the resident having periods not at their baseline it put them at risk for choking and possible aspiration.

Sources: Interviews with RPN and RD; and resident's clinical records
[000766]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
A task was created for a resident by Registered Nurse (RN) to have care provided at specific times. PSW stated throughout their shift they checked/monitored the resident but did not provide care at those specific times.

The resident was put at risk for skin breakdown and discomfort when not provided care as per the plan of care.

Sources: resident's clinical records; interviews with PSW.
[000766]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each

of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure staff reported an outbreak of disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act immediately to the Director.

Rationale and Summary
A disease outbreak was declared in the home. According to the CI, the outbreak was reported to the Ministry of Long-Term Care (MLTC) on the following day. DOC stated they are aware of the reporting requirements and did not immediately report the outbreak.

By not reporting certain matters to the Director resulted in the Director not immediately being aware of incidents occurring in the home.

Sources: Interview with DOC; and CIS report.
[000766]