Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2014	2014_253514_0029	L-000696-14	Follow up

Licensee/Titulaire de permis

HANOVER NURSING HOME LIMITED
700 19TH AVENUE, HANOVER, ON, N4N-3S6

Long-Term Care Home/Foyer de soins de longue durée

HANOVER CARE CENTRE
700-19TH AVENUE, HANOVER, ON, N4N-3S6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RUTHANNE LOBB (514)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 15, 16 ,17, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument Coordinator, 3 Personal Support Workers, 1 Registered Practical Nurse, 1 Maintenance Worker, and 1 Housekeeping Aide.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas, observed residents and the care provided to them, reviewed clinical records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Pain
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times as evidenced by:

LTCH, 2007, c.8, s. 8 (3) has been the subject of a previous non-compliance WN, VPC issued November 28, 2013 (Inspection 2013_171155_0049).

LTCH, 2007, c.8, s.8 (3) has been the subject of a previous non-compliance WN, CO#001 issued June 27, 2014 (Inspection 2014 _25314_0018).

A review of the schedule from August 24-October 14, 2014 (12 hour shifts), revealed that a registered nurse was on duty and present in the home 35/84 shifts (42% of the time). This was confirmed by the Director of Care.

Interview with Director of Care, confirmed that the home continues to have challenges staffing the home at all times with Registered Nursing staff. The Director of Care revealed that currently the home has two Registered Nurses on leave and and one Registered Nurse with limited availability. There are currently three Registered Nursing staff working at the home.

Interview with the Administrator revealed that although the home has recruited for Registered Nursing positions through advertisements in the local newspaper from June 2014-September 2014, the home has not received any applicants for vacant Registered Nursing positions. The Administrator acknowledged that the home is not currently recruiting for any Registered Nursing positions and indicated that the home has not utilized any other recruitment strategies for Registered Nursing positions to date. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, as evidenced by:

O.Reg 79/10, s. 15 (1) has been the subject of a previous non-compliance WN, CO#002 issued June 27, 2014 (Inspection 2014 _25314_0018).

A Bed Entrapment Risk Assessment was conducted on the home's 41 beds on June 16, 2014 by an external company. The Risk Assessment identified that 20/41(49%) beds failed Zones 1 and/or 2 with recommendations that 17 beds and 3 mattresses be replaced. The Administrator indicated that no other safety solutions were suggested by the company for those failed beds, until new beds and mattresses could be purchased by the home.

Seven beds that were identified on the Bed Entrapment Risk Assessment as having failed Zones 2, were observed on October 15, 2014 by Inspector #514 to have ongoing potential entrapment concerns in Zone 2, due to the movement of the mattresses from side to side on the bed.

The Director of Care, Administrator and Housekeeping Aide observed and confirmed the potential entrapment concerns for each of the above beds and confirmed steps were not taken to prevent the mattresses from sliding from side to side between the bed rails prior to this inspection.

The Director of Care confirmed that all above beds require both side rails be up at all times when the resident is in bed.

The Administrator confirmed that it is the home's expectation that where bed rails are used, steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, as evidenced by:

Related non-compliance O.Reg 79/10, s. 48(1) has been previously issued June 27, 2014 WN, CO#007(Inspection 2014 _25314_0018).

On October 16, 2014, a review of clinical data of five residents, who had falls between August 23-October 17, 2014 revealed that no post-fall assessments had been conducted for these residents.

An interview with the Director of Care and the Resident Assessment Instrument Coordinator
confirmed that these residents should have had a post-falls assessment completed, using a clinically appropriate assessment instrument that is specifically designed for falls, but acknowledged that the home does not have any post-fall assessment instrument that is available for use by staff. [s. 49. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

Ontario

Ministry of Health and Long-Term Care

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COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 107. (3)	CO #003	2014_253514_0018	514
O.Reg 79/10 s. 110. (2)	CO #004	2014_253514_0018	514
O.Reg 79/10 s. 221. (2)	CO #005	2014_253514_0018	514
O.Reg 79/10 s. 48. (1)	CO #007	2014_253514_0018	514
O.Reg 79/10 s. 8.	CO #006	2014_253514_0018	514

Issued on this 31st day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTHANNE LOBB (514)
Inspection No. / No de l'inspection :	2014_253514_0029
Log No. / Registre no:	L-000696-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 31, 2014
Licensee / Titulaire de permis :	HANOVER NURSING HOME LIMITED 700 19TH AVENUE, HANOVER, ON, N4N-3S6
LTC Home / Foyer de SLD :	HANOVER CARE CENTRE 700-19TH AVENUE, HANOVER, ON, N4N-3S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA WEPPLER

To HANOVER NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_253514_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The Licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s.8. (3) to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email at Ruthanne.Lobb@ontario.ca by November 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times as evidenced by:

LTCH, 2007, c.8, s. 8 (3) has been the subject of a previous non-compliance WN, VPC issued November 28, 2013 (Inspection 2013_171155_0049).

LTCH, 2007, c.8, s.8 (3) has been the subject of a previous non-compliance WN, CO#001 issued June 27, 2014 (Inspection 2014 _25314_0018).

A review of the schedule from August 24-October 14, 2014 (12 hour shifts), revealed that a registered nurse was on duty and present in the home 35/84 shifts (42% of the time). This was confirmed by the Director of Care.

Interview with Director of Care, confirmed that the home continues to have challenges staffing the home at all times with Registered Nursing staff. The Director of Care revealed that currently the home has two Registered Nurses on leave and and one Registered Nurse with limited availability. There are currently three Registered Nursing staff working at the home.

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(514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_253514_0018, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for maintaining compliance with O. Reg. 79/10, s. 15 (1) to ensure that where bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email, at Ruthanne.Lobb@ontario.ca by November 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, as evidenced by:

O.Reg 79/10, s. 15 (1) has been the subject of a previous non-compliance WN, CO#002 issued June 27, 2014 (Inspection 2014 _25314_0018).

A Bed Entrapment Risk Assessment was conducted on the home's 41 beds on June 16, 2014 by an external company. The Risk Assessment identified that 20/41(49%) beds failed Zones 1 and/or 2 with recommendations that 17 beds and 3 mattresses be replaced. The Administrator indicated that no other safety solutions were suggested by the company for those failed beds, until new beds and mattresses could be purchased by the home.

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The Administrator confirmed that it is the home's expectation that where bed rails are used, steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

(514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2015

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 49 (2) to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email, at Ruthanne Lobb@ontario.ca by November 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident has fallen if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, as evidenced by:

Related non-compliance O.Reg 79/10, s. 48(1) has been previously issued June 27, 2014 WN, CO#007(Inspection 2014 _25314_0018).

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An interview with the Director of Care and the Resident Assessment Instrument Coordinator
confirmed that these residents should have had a post-falls assessment completed, using a clinically appropriate assessment instrument that is specifically designed for falls, but acknowledged that the home does not have any post-fall assessment instrument that is available for use by staff.

(514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31st day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ruthanne Lobb

Service Area Office /
Bureau régional de services : London Service Area Office