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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 20, 2018	2018_737640_0024	016778-18	Critical Incident System

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19, 2018, as an off-site inspection.

During the course of the inspection, the following Critical Incident Report (CIR)was reviewed:
- CIR #2770-000002-18 related to allegation of abuse of a resident by anyone
The following CIR was conducted as an inquiry:
- CIR #2770-000003-18 related to unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with Administrator, Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator and RPN #100.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a report was submitted to the Director regarding the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

On June 29, 2018, resident #002 physically abused resident #001 that resulted in resident #001 becoming fearful it may occur again.

The home submitted a Critical Incident Report to the Director on July 5, 2018.

During an interview with the Administrator, they told the Long-Term Care Homes (LTCH) Inspector that there was an immediate investigation conducted by the nurse in charge following the incident that was documented in the home's electronic incident reporting system.

They told the LTCH Inspector that the results of that investigation and the action taken as a result was not submitted to the Director as required.

The Administrator acknowledged that the home did not submit the results of their investigation and the actions taken as a result of that investigation to the Director. [s. 23. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur was to immediately report the suspicion and the information upon which is was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On June 29, 2018, resident #002 physically abused resident #001 that resulted in resident #001 becoming fearful it may occur again.

The home submitted a CIR to the Director on July 5, 2018.

During an interview with the Administrator, RAI/MDS Coordinator and RPN #100, they told the LTCH Inspector that resident #002 frequently wandered and could become aggressive at times. They stated that resident #001 was fearful of a recurrence.

The Administrator acknowledged the Director was not informed immediately of this incident. [s. 24. (1) 2.]

Issued on this 20th day of November, 2018

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

Original report signed by the inspector.