

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: May 14, 2025

Inspection Number: 2025-1261-0001

Inspection Type:

Critical Incident

Licensee: Hanover Nursing Home Limited

Long Term Care Home and City: Hanover Care Centre, Hanover

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-2, 5- 9, 13-14, 2025

The following intake(s) were inspected:

- Intake: #00138006 - CI #2770-000001-25 Related to an Enteric Outbreak.
- Intake: #00142335 - CI #2770-000002-25: Related to a fall.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

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: O. Reg. 246/22, s. 93 (2) (a)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

- (a) cleaning of the home, including,
 - (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
 - (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The Licensee failed to ensure that contact surfaces of housekeeping cart were clean. Staff acknowledged the housekeeping cart was not clean but did clean the cart entirely and there is now a process in place to ensure appropriate cleaning of the cart.

Sources: Observations, Homes Policy and interview with Staff.

Date Remedy Implemented: May 6, 2025

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

transferring and positioning devices or techniques when assisting residents.

The Licensee failed to ensure that staff used a safe transfer technique on more than one occasion following a resident's falls.

Sources: Resident clinical record, Interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The home failed to ensure that when a resident had several falls, they were assessed using a clinically appropriate assessment instrument that is specifically designed for falls.

Sources: Resident clinical record, Home's policy and Interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The Licensee failed to ensure that altered skin integrity was reassessed at least weekly.

Sources: Home's Policy, resident clinical record and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Licensee failed to perform weekly IPAC audits during an enteric outbreak.

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Effective : February 2025, Section 4: General Recommendations for Confirmed outbreaks the IPAC Lead/Designate is to do weekly IPAC audits for the duration of the outbreak.

Sources: Interview with staff, record review of audits, Home's policies