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

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

Original Public Report

Report Issue Date: June 1, 2023	
Inspection Number: 2023-1111-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Hanover Operating Inc.	
Long Term Care Home and City: The Village Seniors Community, Hanover	
Lead Inspector JanetM Evans (659)	**Inspector Digital Signature** Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2023.06.06 11:41:19 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15 -17, and 23 -26, 2023

The following intake(s) were inspected:
- Intake: #00007408 -Staff to Resident abuse
- Intake: #00011749 - Hypoglycemic event
- Intake: #00015854 - Fall resulting in transfer to hospital.
- Intake: #00022034 - Resident to Resident abuse
- Intake: #00087183 - Complaint -Multiple care concerns, Bill of rights, IPAC, Safety, Medication management system

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 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 their plan of care reviewed and revised when, the resident's care needs changed.

Rationale and Summary

An incident of alleged abuse involving a resident towards a co-resident took place in March 2023.

Staff stated the resident was known to exhibit these behaviours towards staff and residents prior to the alleged incident.

The resident's plan of care did not include any interventions to manage the responsive behaviours prior to the reported incident.

Failure to assess the resident and implement interventions to manage their responsive behaviours resulted in ongoing behaviours which impacted co-residents.

Sources: Critical incident # 2599-000003-23, progress notes, Risk management, care plan, interviews with DOC, resident and staff.

[659]

WRITTEN NOTIFICATION: When reassessment, revision is required.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed to ensure that a resident was reassessed and their plan of care reviewed and revised, when care set out in the plan had not been effective.

Rationale and Summary

A resident had a history of falls, including six falls over a two month period in 2022. Four of the fall incidents occurred when the resident tried to self-transfer and one led to an injury which required transfer to hospital for treatment of injuries.

The resident continued to have falls after the plan of care for falls was revised early in 2023. Two of the three falls documented over a four month period in 2023, related to self transferring for toileting. A toileting plan/schedule had not been implemented for the resident.

The DOC was not certain if a toileting schedule/plan had been considered for the resident.

Failing to ensure different approaches were considered for the resident's plan of care when current interventions were not effective, put the resident at further risk of injury or harm.

Sources: CIS #2599-000024-22, progress notes, care plan, Fall Prevention and Injury Reduction Program CARE5- P10, Fall Prevention and Injury Reduction Workflow, CARE5- P10-E1-LTC, Universal fall prevention strategies P10-E2-LTC, Risk management, post fall assessments, interviews with DOC and staff.
[659]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.N
Non-compliance with: FLTCA, 2021, s. 25 (2) (e)

The licensee has failed to ensure that their written policy in place to promote zero tolerance of abuse and neglect of residents, contained procedures for staff to follow when responding to alleged, suspected or witnessed sexual abuse occurred, including the assessment of a resident for capacity to give consent.

Rationale and Summary

A staff member was alerted to check on a resident and observed them inappropriately touching a co-resident. They separated the residents and notified nursing staff.

The home's procedures for Zero Tolerance of Abuse and Neglect directed staff to complete a nursing assessment of the resident to determine if there was any injury. The resident was to be interviewed and this included residents with a cognitive impairment, and non-verbal signs were to be documented. The policy did not provide direction for staff in relation to determining if the conduct was consensual or not at the time of the incident.

The DOC said their policy of non-abuse did not provide direction to staff on how to determine if a resident's conduct was consensual or not, at the time of incidents.

Failing to have a policy that provides directions for staff related to assessing consent in the moment, in relation to incidents which may constitute sexual abuse, poses a risk that the licensee may not take the necessary steps to respond to these incidents.

Sources: Critical Incident 0965-000003-22, progress notes, risk management, policy: Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01, last reviewed: January 2022, Interviews with ED and DOC.

[659]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (g)

The licensee has failed to comply with their policy to promote zero tolerance of abuse, when they did not follow the procedures for investigating and responding to the allegations of abuse of a resident by a co-resident.

Rationale and Summary

The licensee's Abuse program, included procedures for investigating actual, alleged or suspected abuse and documentation and maintenance of an investigation file.

The home submitted a critical incident to the Director in March 2023, related to allegations of abuse.

The home did not have an investigation file for this incident, nor had they obtained written or signed statements or documented interviews with residents or staff.

The DOC acknowledged they did not follow their home's investigation procedures/toolkit for investigating incidents of resident to resident abuse and they did not document an interview with the resident.

The home's failure to follow their prevention of abuse and neglect of a resident policy in relation to investigating incidents of alleged abuse could have resulted in further incidents.

Sources: Critical Incident 0965-000003-22, Resident non abuse program, ADMIN1-P10-ENT revised March 31, 2023, LTC investigation of abuse/neglect, ADMIN1-O10.02 Revised March 31, 2022, Revera Resident Non-Abuse Toolkit for Conducting an Alleged Abuse Investigation, November 2010, resident progress notes, plan of care, risk management, interview with DOC.

[659]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure the person who had reasonable grounds to suspect that abuse of two residents had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

In accordance with FLTCA, 2022, s. 154 (3), the licensee is vicariously liable when staff had knowledge of an alleged incident of abuse and had not immediately reported this.

Rationale and Summary

A) A staff member witnessed a co-staff member act inappropriately towards a resident during care. The resident was visibly upset following the incident.

The PSA told a co-worker about the incident but neither staff member immediately reported this to the home.

Approximately three weeks later, a nurse (RN) was notified of the alleged incident of abuse and notified the on call manager.

The DOC acknowledged they were advised of the incident by the on call manager, but had not reported to the Ministry of Long-Term Care (MLTC) until two days after they were informed.

Failure to immediately report alleged abuse of the resident to the Director, limited the Director's ability to intervene in a timely manner if required.

Sources: Home's investigation, Risk management, Critical incident # 2599-000019-22, interviews with DOC and staff.

[659]

B) An incident of suspected abuse of a resident was documented in a progress note.

The DOC stated they were not told about the alleged incident, but had they known they would have reported it to the Director.

Failure to immediately report alleged abuse of the resident to the Director, limited the Director's ability to intervene in a timely manner if required as well as impacted the home’s ability to initiate a timely investigation into the incident.

Sources: resident’s progress note February 5, 2023. Interview with DOC and staff.

[659]