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

Original Public Report

Report Issue Date: June 1, 2023	
Inspection Number: 2023-1261-0001	
Inspection Type: Proactive Compliance Inspection (PCI)	
Licensee: Hanover Nursing Home Limited	
Long Term Care Home and City: Hanover Care Centre, Hanover	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.06.02 10:38:30 -04'00'
Additional Inspector(s) Amanpreet Kaur Malhi (#741128)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9-12, 15-18, 2023

The following intake(s) were inspected:

- Intake: #00087063 – Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed related to nutrition and hydration.

The resident's care plan included a specific intervention related to nutrition and hydration. The resident was observed without this intervention in place.

The Food Service Manager (FSM) stated that the resident's plan of care was not reflective of their current care needs due to a change in their health status. The resident's care plan was reviewed and revised to accurately reflect the interventions they required.

Sources: Observations, the resident's care plan, interviews with the FSM and other staff.

Date Remedy Implemented: May 15, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 79 (1) 8.

The licensee failed to ensure that a resident was provided with an assistive device to safely eat as comfortably and independently as possible.

The resident required a specific device to assist with meals. The resident was observed without this assistive device during a meal.

A Personal Support Worker (PSW) stated that the resident no longer required the assistive device.

The FSM Manager confirmed that the resident still required the assistive device and updated the home's nutrition communication tool to include all residents who required the assistive device.

Sources: Observations, the resident's care plan, interviews with the FSM and other staff.

Date Remedy Implemented: May 11, 2023

[#753]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (d)

The licensee failed to ensure that an explanation of the duty under section 28 to make mandatory reports was posted within the home.

The Administrator and Director of Care (DOC) posted the duty to make mandatory reports on the bulletin board at the entrance of the home.

Sources: Observations, interview with the DOC.

Date Remedy Implemented: May 15, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (r)

The licensee failed to ensure that the required information on the explanation of whistle-blowing protection was posted within the home.

The Administrator and DOC posted the Whistle-Blowing Protection policy (#30-220, last revised 04/30/22) on the bulletin board at the entrance of the home.

Sources: Observations, interview with DOC.

Date Remedy Implemented: May 15, 2023

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

The Administrator and DOC posted the policy to promote zero tolerance of abuse and neglect on the bulletin board at the entrance of the home.

Sources: Observations, interview with the DOC.

Date Remedy Implemented: May 15, 2023

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 138 (1) (b)

The licensee failed to ensure that the bin containing controlled substances within the locked medication cart, parked inside the secured medication room, was properly locked.

A Registered Nurse (RN) used their key to open the medication cart parked inside the secure medication room. However, they opened the controlled substances bin located inside the medication cart without utilizing a key. The RN acknowledged the possibility of forgetting to lock the controlled substance bin, but promptly secured it with their keys afterward.

Sources: Observations, and interview a RN.

Date Remedy Implemented: May 10, 2023

[#741128]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care related to their bathing requirements.

Rationale and Summary

The resident's care plan and task care record directed staff to provide the resident with different types of bathing methods.

A Registered Practical Nurse (RPN) stated that the resident's task care record indicated the correct bathing method, whereas the resident's care plan was not reflective of the type of bath they required.

The resident was at risk of receiving the incorrect bathing method when their plan of care did not clearly document their current bathing requirements.

Sources: Resident's plan of care including their care plan and task care record, interview with a RPN and other staff.

[#741128]

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee failed to ensure that the home had an Infection Prevention and Control (IPAC) Lead whose primary responsibility was the home's IPAC Program.

Rationale and Summary

The home's DOC and Activities Director co-led the IPAC program in the home. Combined, they estimated that they worked 16 to 18 hours per week conducting IPAC related tasks. However, documentation did not substantiate the minimum requirement of 17.5 hours was being used for IPAC related tasks.

The DOC acknowledged that the home did not meet the current requirements related to the IPAC Lead in the home.

When the home did not have an IPAC Lead whose primary responsibility was the home's IPAC program, this may have contributed to home's IPAC program not meeting all the IPAC training and education components required by the Ministry of Long-Term Care (MLTC).

Sources: Documentation from the DOC, interviews with the IPAC Leads.

[#753]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee failed to ensure that, unless otherwise directed by the Minister, at least once in every year a survey was taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary

A resident stated that in last six years, they did not recall completing a Resident Experience Survey.

The Administrator acknowledged that a Resident and Family/Caregiver Experience Survey had not been conducted for at least five to six years.

Failure to complete a survey of residents, family members and caregivers was a missed opportunity to collaborate and capture information of importance to residents and their family members.

Sources: Interviews with the Administrator and a resident, most recent Family Experience Survey (dated 2017).

[#753]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee failed to seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey.

Rationale and Summary

A Resident's Council Attendee stated that the home had not sought the advice of the Residents' Council in creating the three questions included in the current Resident Experience Survey.

The Administrator acknowledged that the current questions included were developed to reflect the home's Continuous Quality Improvement (CQI) priority areas for improvement.

Sources: Resident Council Meeting Minutes January, March and April 2023, interviews with the Administrator and a resident, Resident Survey (May 2023), CQI Interim Report (July 14, 2022).

[#753]

WRITTEN NOTIFICATION: Duty to respond

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

When the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee failed, within 10 days of receiving the advice, to respond to the Residents' Council in writing.

Rationale and Summary

Resident's Council expressed several concerns as well as general recommendations.

The Resident Council attendee stated that a written response was not provided to Resident's Council when concerns or recommendations were shared.

The Activities Director stated that they waited until a concern was expressed more than once to complete a concern form. Once the form was completed and a response was received, the response was not shared until the next Resident Council Meeting, nor was the response accessible to Resident's Council to be reviewed in the meantime.

Sources: Resident Council Meeting Minutes January, March and April 2023, Resident Council Report of Concerns Forms January to April 2023, interviews with the Activities Director and resident #007.

[#753]

WRITTEN NOTIFICATION: Family Council

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7)

The licensee failed to ensure that on an ongoing basis, they advised residents' families and persons of importance to residents of the right to establish a Family Council; and failed to convened semi-annual meetings to advise such persons of the right to establish a Family Council.

Rationale and Summary

No Family Council had been established in the home since January 2020. Between January 2020 and April 14, 2023, the home did not advise residents' families and persons of importance to residents of the right to establish a Family Council on an ongoing basis, nor were any meetings held to advise such persons of the right to establish a Family Council.

Failure to promote the establishment of a Family Council in the home was a missed opportunity to

collaborate with residents' families and capture information of importance to residents and family members.

Sources: Interview with Administrator and other staff, Family Council Poster (April 14, 2023).

[#753]

WRITTEN NOTIFICATION: Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee failed to ensure that a PSW received IPAC training prior to performing their responsibilities.

Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities.

Rationale and Summary

A PSW did not complete their IPAC related training and education until approximately seven weeks after their start date.

The IPAC Lead stated that IPAC related education and training for new hires was to be completed prior to the end of their 10 orientation shifts.

Sources: Interviews with an IPAC Lead and other staff, a PSW's Surge Training Records.

[#753]

WRITTEN NOTIFICATION: Drug Destruction and Disposal Policy

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)

The licensee failed to ensure that the home's drug destruction and disposal policy was compliant with the legislative requirements necessitating the safe and secure storage of controlled substances to be destroyed in a double-locked area within the home, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs.

In accordance with O. Reg 246/22, s. 148 (2) (2), the drug destruction and disposal policy must provide that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked area within the home, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary

The home's Drug Disposal and Destruction policy stated that destruction may take place during shift count if the nurse on duty can save the dose to be destroyed in the double-locked section of the medication cart until shift change time.

Multiple registered staff including the DOC stated that controlled drugs that were for disposal or destruction were kept in the locked controlled substances bin in the locked medication cart with other drugs that were available for administration. The controlled drugs were stored in the box until shift count occurred or until another team member was available to carry out the drug disposal or destruction.

By failing to comply with the legislative requirements, controlled substances that were to be disposed/destroyed were not securely stored.

Sources: Interviews with the DOC and other staff, Drug Destruction Policy, Section C (#5-4, last revised 11/20)

[#741128]

WRITTEN NOTIFICATION: Cooling Requirements

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (3)

The licensee failed to evaluate and update the home's Heat-Related Illness (HRI) prevention and management plan annually.

Rationale and Summary

The home's HRI Prevention and Management policy was last revised on May 30, 2016.

The policy directed staff to implement HRI preventative measures when the temperature readings were over 30 degrees Celsius. However, Ontario Regulations 246/22, section 23 (4) (a) and (b) requires the

home to implement HRI prevention measures every year during the period from May 15 to September 15 and it shall also be implemented:

a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and

b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

The DOC acknowledged that the HRI policy was outdated, and the prevention and management plan was not evaluated and updated annually.

By not evaluating and updating the HRI Prevention and Management policy annually, there was an increased risk of ineffective screening, monitoring and management of resident's at risk of HRI.

Sources: HRI Prevention and Management Policy (#100-525), interview with the DOC.

[#741128]

WRITTEN NOTIFICATION: Air Temperature

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee failed to ensure that the home monitored and documented temperatures in the designated areas at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night during the period from October to April.

Rationale and Summary

The home's Temperature Record Sheets showed that air temperatures were monitored and documented in the designated areas annually from May to September only.

A RPN stated that the air temperature recordings at the home started on May 11, 2023, this year and were not conducted earlier as it was chilly. The DOC stated that air temperatures were only recorded in the designated areas of the home from May to September, and this period may be extended if there was a hot October.

By not monitoring and documenting air temperatures within the home from October to April, there was a risk that the home would not immediately recognize any temperature changes that may compromise the health and safety of residents.

Sources: Temperature Record Sheets 2020, 2021, 2022, and 2023, interviews with the DOC and other staff.

[#741128]

WRITTEN NOTIFICATION: Menu Planning

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee failed to ensure that the planned menu items were offered and available during lunch.

Rationale and Summary

Multiple observations of the lunch meal and planned menu items showed that the desert listed on the planned daily menus were not reflective of the desert options that were offered to residents.

Both the Cook and FSM acknowledged that the posted menu should have been updated to reflect the desert options offered to residents. Additionally, the planned seven-day menu was not consistent with the planned daily menu's that were posted.

When the planned menu items were not available, this may have potentially impacted the resident's dining experience.

Sources: Observations, interviews with the FSM and other staff.

[#753]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)

The licensee failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Subsection 9 states that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate

residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

Rationale and Summary

There was no documentation to substantiate that analysis for trends of monthly surveillance data had been completed in the home for the previous two months.

An IPAC Lead acknowledged that the home had not completed the analysis.

Sources: Interview with an IPAC Lead.

[#753]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The licensee failed to ensure their continuous quality improvement (CQI) committee was composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

Rationale and Summary

The home's CQI Committee did not include the home's Medical Director, the home's pharmacy service provider, or a pharmacist from the pharmacy service provider, at least one employee of the licensee who is a member of the regular nursing staff of the home, at least one employee of the licensee who has

been hired as a personal support worker, one member of the home's Residents' Council, and one member of the home's Family Council, if any.

When all the required members were not included in the CQI Committee, representation from all areas of the home to provide suggestions for improvement opportunities could not be considered.

Sources: CQI Interim Report July 2022, interview with the Administrator.

[#753]

WRITTEN NOTIFICATION: Continuous Quality Improvement Report

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (b)

The licensee has failed to ensure that the CQI interim report prepared under the O. Reg. 246/22 s. 168 (5), was provided to the Resident's Council.

Rational and Summary

The Fixing Long-Term Act, 2021, and O. Reg. 246/22 came into effect on April 11, 2022.

As per O. Reg. 246/22 s. 168 (5), every licensee of the long-term care home (LTCH) shall, within three months of coming into force of this section, prepare an interim report for the 2022-2023 fiscal year.

The LTCH's interim report titled "Continuous Quality Improvement – Interim Report" was completed on July 14, 2022.

The Resident's Council Attendee was not familiar with the term CQI and did not recall any information related to the improvements to accommodations, care, services, programs, and goods provided to the residents being discussed in Resident Council meetings. The home was unable to provide any supporting documentation to substantiate that the CQI Report had been discussed or shared with Resident Council.

Not providing the Resident's Council with the CQI Interim Report may have impacted their ability to participate in the development of the home's quality improvement initiatives.

Sources: CQI Interim Report (dated July 14, 2022), interviews with a resident and the Activities Director and other staff.

[#753]

WRITTEN NOTIFICATION: Continuous Quality Improvement Report

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (c) ii.

The interim report prepared under subsection (5) failed to include a written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative.

Rationale and Summary

A) The home's interim CQI Report, posted to their website included a written description of the process used to identify the home's priority areas for quality improvement, however the report stated that the home selected indicators and incorporated opportunities for improvement that were identified in part, through the Resident Satisfaction Survey. However, there had not been a Resident Satisfaction Survey completed in the home for at least five years.

B) The Administrator acknowledged that the policies, procedures and protocols for CQI initiatives were not included in the report.

When policies, procedures and protocols for CQI were not included in the report, residents and their families were not provided the opportunity to fully participate in the Quality Improvement Program and improving the quality of care, services, and accommodations.

Sources: CQI Interim Report (dated July 14, 2022), interview with the Administrator.

[#753]

WRITTEN NOTIFICATION: Orientation

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)

The licensee shall ensure that the training for staff related to IPAC required under paragraph 9 of subsection 82 (2) of the Act included signs and symptoms of infectious diseases.

Rationale and Summary

The IPAC Lead acknowledged that staff were not currently receiving IPAC training and education related

to the signs and symptoms of infectious diseases.

Sources: Interviews with IPAC Lead #101 and other staff, Surge Training Modules: Public Health Ontario: 4 Moments of Hand Hygiene and Just Clean Your Hands An Introduction, RICN Super Bugs: A Nightmare on your hands and RICN Grand Prix of PPE, RICN Best Practices for Environmental Cleaning Module 1, 2, 3, and 4a.

[#753]

WRITTEN NOTIFICATION: Orientation

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)

The licensee shall ensure that the training for staff related to IPAC required under paragraph 9 of subsection 82 (2) of the Act included what to do if experiencing symptoms of infectious disease.

Rationale and Summary

The IPAC Lead acknowledged that staff were not currently receiving IPAC training and education on what to do if experiencing symptoms of infectious disease.

Sources: Interviews with IPAC Lead #101 and other staff, Surge Training Modules: Public Health Ontario: 4 Moments of Hand Hygiene and Just Clean Your Hands An Introduction, RICN Super Bugs: A Nightmare on your hands and RICN Grand Prix of PPE, RICN Best Practices for Environmental Cleaning Module 1, 2, 3, and 4a.

[#753]

WRITTEN NOTIFICATION: Orientation

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary

The IPAC Lead acknowledged that staff were not currently receiving IPAC training and education related to the handling and disposing of biological and clinical waste including used personal protective equipment.

Sources: Interviews with IPAC Lead #101 and other staff, Surge Training Modules: Public Health Ontario: 4 Moments of Hand Hygiene and Just Clean Your Hands An Introduction, RICN Super Bugs: A Nightmare on your hands and RICN Grand Prix of PPE, RICN Best Practices for Environmental Cleaning Module 1, 2, 3, and 4a.

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