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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
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Original Public Report

Report Issue Date August 30, 2022
Inspection Number 2022_1111_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Hanover Operating Inc.

Long-Term Care Home and City
The Village Seniors Community, Hanover

Lead Inspector
Kim Byberg (729)

Additional Inspector(s)
Alicia Campbell (741126)
Amanpreet Malhi (741128)
Kristen Owen (741123)

Inspector Digital Signature
Kimberly Byberg
Digitally signed by Kimberly Byberg
Date: 2022.08.31 14:31:04 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 8-12, 2022.

The following intake(s) were inspected:

The following intakes were completed in this critical incident inspection:

- Log # 008651-21, related to an allegation of improper care;
- Log # 001514-22, and Log # 017228-21, related to an allegation of neglect of a resident;
- Log # 011155-21, related to an incident that caused a significant change in health condition requiring transfer to hospital.

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

Falls Prevention and Management
Infection Prevention and Control (IPAC)
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

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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#01 remedied pursuant to FLTCA, 2021, s. 154(2)
O. Reg. 246/22 s. 93(2)(b)(iii)

During the inspection an expired chemical product used to clean general and high touch surfaces was observed in the housekeeping room. A Staff member confirmed that the container that was expired was the product they were diluting and were using to clean each day.

The DOC and the maintenance staff member were made aware of the expired product during an interview by inspector #729.

The DOC and staff member #110 checked all the inventory of cleaning chemicals in the home and discarded the expired products.

Date Remedy Implemented: August 12, 2022 [729]

WRITTEN NOTIFICATION – TRANSFERRING AND POSITIONING TECHNIQUES

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1
Non-compliance with: **O. Reg. 79/10 s. 36**

The licensee has failed to ensure that two personal support workers (PSWs) used safe transferring and positioning techniques when repositioning a resident.

Rationale and Summary

A resident required extensive to total assistance for care with the assistance of one to two staff members. Two PSW's attempted to provide care for the resident, the staff did not prepare the environment or communicate with one another prior to care being provided, and as a result the resident suffered injuries causing a significant change in their health status.

The homes' policy titled Safe Resident Handling, CARE6-O10.02, effective date August 31, 2016, reviewed March 31, 2022, modified March 31, 2019, indicated basic principles of safe resident handling included staff were to discuss the procedures with the resident and their partner, prepare for the unexpected, and prepare the environment by ensuring adequate lighting is available.

The PSW's acknowledged the environment was not prepared and there was miscommunication while caring for the resident.

When two PSW's did not effectively communicate and did not prepare the environment prior to repositioning a resident, it caused and incident to occur with significant injuries to the resident.

Sources: CIS report, statements from Village of Seniors Community internal investigation completed, Safe Resident Handling policy, CARE6-O10.02, effective date August 31, 2016, reviewed March 31, 2022, modified March 31, 2019, and interviews with PSW's and DOC #106.

[741123]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50 (2)(b)(i)

The licensee has failed to ensure the home's New Skin Impairment/New Wound Assessment policy and procedures included in the required Skin and Wound Care program were complied with for a resident.

Rationale and Summary

In accordance with O. Reg. 79/10, s. 8 (1) (b), the home was required to ensure the Skin and Wound Care program polices were complied with.

Specifically, staff did not comply with the home's policy and procedure "LTC-New Skin Impairment/New Wound Assessment, CARE 12-010.02 effective August 21, 2016".

Report was given to a registered practical nurse (RPN) during their day shift that a resident had a new area of impaired skin integrity.

The resident was not assessed by a member of the registered nursing team and a skin and wound assessment was not completed until the following day shift.

The homes' policy titled LTC-New Skin Impairment/New Wound Assessment, CARE 12-010.02 effective August 21, 2016, stated that once skin impairment was reported or identified, the nurse would complete the initial assessment by using the point click care (PCC) skin and wound care application (app).

A resident that exhibited impaired skin integrity was not assessed by the RPN when they were notified of the impairment during the day shift or subsequent shifts that day despite receiving verbal report that a resident had a new area of skin impairment. By not completing a skin and wound assessment at the time the new area of impairment was identified, put the resident at risk of the impairment deteriorating when assessment and interventions were not initiated by a registered staff member.

Sources: Record review of a resident's progress notes, shift report communication book, skin and wound assessment, and eTAR. Interview with PSW's, RPN's and DOC #106. Review of the home's investigation notes. Home's policy LTC-New Skin Impairment/New wound assessment, CARE 12-010-02, Effective: Aug 31, 2016, Reviewed: March 31, 2022.

[729]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50 (2)(b)(iii)

The licensee has failed to ensure that when a resident developed an area of impaired skin integrity that they were assessed by a registered dietitian (RD).

Rationale and Summary

A resident developed a new area of impaired skin integrity. A referral by the registered staff to the dietitian, or a dietary assessment by the RD was not completed.

The home's skin and wound lead completed the initial assessment of a resident's new area of skin impairment. They stated that the resident's wound was manageable; therefore, they did not complete or need a referral to the dietitian.

DOC #106, confirmed that a referral to the RD was to be completed.

The home's skin and wound care policy #CARE12-010.02, effective August 16, 2016, reviewed on March 31, 2022, stated that a referral to the RD for new, worsening, and healed wounds as per the regularity/legislative requirement was to be completed. The home was to complete the RD nutrition care referral form online.

The home not ensuring that a resident was assessed by an RD related to the new area of skin impairment may have resulted in the resident not receiving recommended nutritional interventions for healing.

Sources: Review of electronic dietary referrals and assessments specifically related to skin and wound care, progress note review. Interview with RPN's, and DOC #106. Skin and Wound Care policy #CARE12-010-02

[729]

WRITTEN NOTIFICATION PLAN OF CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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Non-compliance with: **LTCHA, 2007 s. 6 (7)**

The licensee has failed to ensure that skin and wound treatments were provided for a resident as set out in the plan of care.

Rationale and Summary

A Resident's Electronic Treatment Administration Record (eTAR) instructed registered staff to provide wound care every day shift with a prescribed treatment cream and complete a dressing change to their area of impaired skin integrity.

The eTAR was signed by an RPN as completed for two consecutive days; however, the RPN acknowledged that they did not complete the treatment as per the eTAR. Two days after the treatment was not completed, the physician ordered additional wound care interventions to promote healing of the impaired skin integrity.

There was no physician order, eTAR or electronic medication administration record (eMAR) for the initial treatment of the impaired skin as indicated as part of the wound care directions on the eTAR despite staff signing for the application of the treatment for three weeks.

A Resident's skin and wound care regime was at risk of being negatively impacted when the RPN did not complete daily dressing changes. In addition, the resident's wound management program was also at increased risk for harm as an RPN did not obtain or document the treatment order and consequently, it was not applied to the resident for three weeks.

Sources:
Electronic Treatment Administration Record (eTAR), Investigation Notes, interviews with RPN's, interview with an RN, Interview with DOC #106, and Physician's Digiorder set.

[711428]