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: October 30,2023	
Inspection Number: 2023-1111-0003	
Inspection Type: Critical Incident	
Licensee: Hanover Operating Inc.	
Long Term Care Home and City: The Village Seniors Community, Hanover	
Lead Inspector Dianne Tone (000686)	**Inspector Digital Signature** Dianne Elizabeth Tone Digitally signed by Dianne Elizabeth Tone Date: 2023.10.31 09:11:23 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12-13, 16-20, 2023

The following intake(s) were inspected:
- Intake: #00088782- Allegation of Neglect.
- Intake: #00094828 - Hypoglycemic event.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 7.

The licensee failed to ensure that the plan of care for a resident included at a minimum the type of level of assistance that was required for eating.

Rational and Summary:

A resident required assistance with their meals.

The resident's plan of care did not include the type of assistance required.

Director of Care (DOC) stated the plan of care should have included the type of assistance required.

When the resident plan of care did not include the type of assistance required for eating, staff may not know the level of assistance to provide.

Sources: Resident care plan, interview with DOC, interview with a PSW.
[000686]

WRITTEN NOTIFICATION: Nutrition Care and Hydration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee failed to ensure that interventions were implemented to mitigate and manage risk for a resident’s nutritional care.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the implementation of interventions to mitigate and manage risk related to Nutrition care and Hydration programs and must be complied with.

Specifically, staff did not comply with interventions: Members of the interdisciplinary team provide regular monitoring, follow-up, and assessment to ensure the acceptance and tolerance of diet texture

and fluid consistency, as stated in the policy "LTC-Dysphagia Management and Safe Eating", dated March 31, 2023, which was included in the licensee's Nutritional Care and Hydration Program.

Rational and summary:

When a resident had an incident, there was no documentation and no evidence that assessments or monitoring of a resident were completed.

The DOC stated that they would have expected assessments to be completed and the resident monitored for at least 72 hours.

An RN stated there should have been documentation.

By not assessing and documenting, the resident was put at risk.

Sources: Resident clinical record, Interviews with DOC and RN, Policy CARE7-010.05 Nutritional Care and Hydration.

[000686]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)

The licensee failed to ensure that a quarterly review was undertaken of a medication incident.

Rational and Summary
There was a medication incident involving a resident.

The DOC stated that the medication incident was not reviewed at the home's quarterly medication incident review meeting.

When a medication incident is not reviewed in the quarterly meeting, as required, there is lost opportunity to identify patterns and improve processes.

Sources: resident clinical record, interview with DOC.
[000686]