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
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: December 18, 2024
Inspection Number: 2024-1111-0003
Inspection Type: Critical Incident
Licensee: Hanover Operating Inc.
Long Term Care Home and City: The Village Seniors Community, Hanover

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 9 - 10 and 13, 2024
The inspection occurred offsite on the following date: December 12, 2024

The following intake was inspected in this Critical Incident (CI) Inspection:

- Intake: #00127434 was related to outbreak management

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

Infection Prevention and Control

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)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that a soiled utility room door in the home was kept closed and locked.

During two separate observations, a soiled utility room door in the home was not closed and locked.

The door was immediately closed on both occasions, and a work order was put in for the door as it was not closing properly.

During a subsequent observation, the soiled utility room door was closed and locked.

A work order was completed by the Environmental Service Manager to ensure that the soiled utility room door closed properly.

Sources: Multiple observations of the soiled utility room door, review of the work order submitted for the soiled utility room door, and interviews with staff.

Date Remedy Implemented: December 11, 2024

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Rationale and Summary
In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024, homes are to complete weekly IPAC audits for the duration of an outbreak.

An outbreak was declared. Weekly IPAC audits were not completed for the duration of the outbreak.

The IPAC Lead confirmed that they did not complete weekly IPAC audits during the outbreak.

When weekly IPAC audits were not completed during the outbreak, it was a missed opportunity to ensure adherence to IPAC procedures, and there was an increased risk of infection transmission.

Sources: Record review of the home's outbreak documentation, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024, and interview with staff.