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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Public Report

Report Issue Date: April 3, 2025
Inspection Number: 2025-1111-0001
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 date(s): March 31- April 2, 2025
The inspection occurred offsite on the following date(s): April 2, 2025
The following intake(s) were inspected:

- Intake: #00136995 - 2599-000003-25: Alleged neglect by staff to resident.
- Intake: #00141928 - 2599-000010-25: Outbreak declared March 9-20.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee failed to ensure that, in accordance with Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition, April 2014, hand hygiene is to be performed before serving food to a resident. Additionally, Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, Revision November 2012, states that hand hygiene must be performed immediately after glove removal.

In March, 2025, the inspector observed a dietary aide provide plates of food to residents without performing hand hygiene, after cleaning soiled dishes from resident tables.

In April, 2025, the inspector observed a housekeeping aide doff and don gloves without performing hand hygiene after doffing.

Source: Observations in March and April, 2025, interviews with frontline staff and IPAC Lead, and Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, Revision November 2012 and Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition, April 2014. [000869]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure 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

The licensee failed to ensure that resident symptoms were monitored on each shift for two residents.

Both residents were in isolation for symptoms of an infection. During the residents' isolation periods, one resident was not monitored on each shift on for a day in March. Likewise, the other resident was not documented as being monitored on two overnight and another full day in March, 2025.

Sources: Resident progress notes, interviews with frontline staff, and Director of Care (DOC)/Executive Director (ED). [000869]

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a RPN changed a resident's wound dressings according to their treatment administration record (TAR) on two days in January, 2025.

Sources: The home's investigation notes, resident's TAR, interviews with RPN and DOC/ED. [000870]