Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 15, 2021 | 2021_828744_0019 | 013919-21 | Other |

### Licensee/Titulaire de permis

Hornepayne Community Hospital
278 Front Street P.O. Box 190 Hornepayne ON P0M 1Z0

### Long-Term Care Home/Foyer de soins de longue durée

Hornepayne Community Hospital
278 Front Street P.O. Box 190 Hornepayne ON P0M 1Z0

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

STEVEN NACCARATO (744)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct an Other inspection.**

**This inspection was conducted on the following date(s): October 5-7, 2021.**

**This inspection was a Sudbury Service Area Office initiated inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Maintenance lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) lead, Housekeepers, Dietary Cooks and residents.**

**The Inspector also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, observed the provision of care and services to residents and reviewed relevant health care records, licensee policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Reporting and Complaints**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion act.

The Porcupine Health Unit declared a respiratory outbreak on the long-term care unit of the Hornepayne Community Hospital.

The Director of Care (DOC) confirmed that the Director was not informed of the respiratory outbreak and they were unaware that this critical incident was the responsibility of the home to report.

Sources: Correspondence from the Porcupine Health Unit; Review of the Critical Incident System (CIS) portal; Interview with the DOC. [s. 107. (1) 5.]

2. The licensee has failed to inform the Director within one business day of an injury to a resident in which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

A resident sustained an injury, which resulted in a significant change in the resident's health condition. The DOC confirmed that a critical incident report should have been submitted.

Sources: Review of a resident's electronic progress notes; The home's policy titled "Mandatory Reporting and Critical Incidents in LTC" (Effective date: 5/7/2018); Review of the Critical Incident System (CIS) portal; Interview with the DOC. [s. 107. (3) 4.]

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**Issued on this 15th day of October, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**