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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965
northdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 9, 2023	
Inspection Number: 2022-1416-0002	
Inspection Type: Critical Incident System	
Licensee: Espanola General Hospital	
Long Term Care Home and City: Espanola General Hospital (operating as Espanola Nursing Home-LTC), Espanola	
Lead Inspector Jennifer Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2023.01.10 15:51:08 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date (s): December 13-15, 2022.

The following intakes were completed:

Three Intakes which were related to Disease outbreak.

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

Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports: re: Critical Incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance, or communicable disease as defined by the Health Protection and Promotion Act.

A critical incident (CI) report was submitted for a disease outbreak that was declared nine days earlier.

The IPAC lead confirmed that the outbreak was declared by the Public Health Unit on the specified date. The Director of Care (DOC) stated that they had not submitted the CI report immediately, and they should have.

Sources: CI report; Resident Line list, licensee policy titled “Reporting to the Director”, Interviews with the IPAC Lead, and the DOC.

[691]

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