Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 12, 2018	2018_619550_0007	001924-18	Critical Incident System

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Élisabeth-Bruyère Residence
75 Bruyère Street OTTAWA ON K1N 5C8

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 1, 2, 7, 8, 9 and 10 2018.

This inspection is related to sudden/unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with The Administrator and the Director of Care (DOC).

The inspector also reviewed a critical incident report (CIR) and the resident's health care records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

On a specific date and time, a critical incident report (CIR) was submitted to the Director reporting the unexpected death of resident #010. It was reported on the CIR that the resident was deceased on that same date, 2.5hrs earlier. It was also documented on this report that seven days earlier, resident #010 had started to have a specific symptom and then had developed other symptoms two days later. Four days after the onset of the first symptoms and at a specific time, the resident was having respiratory difficulties breathing and passed away five minutes later.

During an interview, the Administrator confirmed to the inspector that the resident's death was sudden and unexpected. They indicated that the resident passed away on a specific date and not on the date indicated on the CIR as the date of death. They further added that the previous DOC had submitted the CIR upon being informed of the resident's death, which was three days after the resident had passed away. The Administrator did not know that incidents of unexpected or sudden deaths required immediate reporting to the Director.

As such, the sudden/unexpected death of resident #010 was not immediately reported to the Director, it was reported three days later. [s. 107. (1) 2.]

Issued on this 13th day of June, 2018

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

Original report signed by the inspector.