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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 9, 2019	2019_638542_0014	004879-19	Critical Incident System

Licensee/Titulaire de permis

Espanola General Hospital
825 Mckinnon Drive ESPANOLA ON P5E 1R4

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

Espanola General Hospital (operating as Espanola Nursing Home-LTC)
825 Mckinnon Drive ESPANOLA ON P5E 1R4

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

JENNIFER LAURICELLA (542), LISA MOORE (613)

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): April 1, 2019.

One intake was completed during this CI inspection, which was related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer and the Administrator.

The inspector(s) also completed a tour of resident care areas, reviewed health care records, investigation files, as well as licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services

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	Légende 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):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. 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 possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): An unexpected or sudden death, including a death resulting from an accident or suicide.

Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director, identifying the unexpected death of resident #001.

A review of the progress notes identified that resident #001's health status changed and that they were transferred to the hospital for further assessment, and later passed away on the same date at the hospital.

A review of the home's policy titled, "Reporting to the Director (Ministry)" last updated on April 8, 2019, indicated that the home shall immediately report to the Director an unexpected or sudden death, including a death resulting from an accident or suicide.

During an interview with the Chief Nursing Officer (CNO), they stated that there had been some confusion with the doctor at the hospital, as they did not believe that resident #001's death was unexpected; however, the Director Of Care (DOC) had felt it was an unexpected or sudden death. The CNO further stated that they and the DOC then reviewed the events leading to the death and determined that resident #001's death was unexpected or sudden; therefore, they reported it to the Director late. [s. 107. (1)]

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.