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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 28, 2024
Inspection Number: 2024-1230-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Stayner Care Centre Inc.
Long Term Care Home and City: Stayner Care Centre, Stayner

Lead Inspector	**Inspector Digital Signature**
Sharon Perry (155)	Sharon M Perry Digitally signed by Sharon M Perry Date: 2024.04.09 09:12:41 -04'00'

Additional Inspector(s)
Gabriella Del Principe (741734)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19-22 and 25-28, 2024.

The following intake(s) were inspected:

- Intake: #00111308, Proactive Compliance Inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) The licensee failed to ensure that a resident's falls prevention intervention was implemented.

Rationale and Summary

The resident's plan of care indicated they were to have a specific falls prevention intervention in place.

On two different days, Inspector #741734 observed the resident and the falls prevention intervention was not in place.

Failure to ensure that the resident's falls prevention intervention was in place put

the resident at risk as staff members would not have been alerted if the resident was attempting to transfer independently.

Sources: Resident clinical health records, interview with the homes Fall Prevention and Management Lead and observations. [741734]

b) The licensee failed to ensure that a resident was toileted as per their plan of care.

Rationale and Summary

The resident's plan of care for toileting indicated that staff were to toilet the resident upon rising, after meals and before bed.

The resident was observed from 0913 hours, coming out of breakfast until 1445 hours, when the resident was sitting in the lounge after lunch. The resident was not toileted during this time.

Failure to ensure that resident was toileted as per their plan of care resulted in the resident being incontinent and requiring clothing to be changed.

Sources: Resident clinical health records, interview with PSWs, and observations. [741734]