**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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 9, 2016 | 2016_270531_0008 | 002447-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

MANORCARE PARTNERS
6257 Main Street Stouffville ON  L4A 4J3

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

STIRLING MANOR NURSING HOME
218 EDWARD STREET P.O. BOX 220 STIRLING ON  K0K 3E0

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

SUSAN DONNAN (531), DARLENE MURPHY (103), HEATH HEFFERNAN (622), JESSICA PATTISON (197)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 29, March 1, 2, 3, 4, 7 and 8, 2016.**

**The following logs were completed concurrently with this inspection:**
**Log #024249-15 resident sustained a fall and transferred to hospital**
**Log #030351-15 resident to resident abuse**

**During the course of the inspection, the inspector(s) spoke with Residents, Resident Substitute Decision Makers, Resident Council representatives, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Food Services Aides, the Maintenance Supervisor, the Life Enrichment Manager, the Director of Resident Care and the Administrator.**

**During the course of the inspection, the inspectors conducted a tour of the home, made dining room and resident care observations, observed medication administration practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident council minutes, applicable home policies, the home's staffing schedules for the nursing department and the home's staffing plan.**

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

**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**
**1 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 | Legendé<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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made by inspectors from February 29 to March 4, 2016:

Res. #24's room –a three inch round hole in the drywall behind the door
-wallpaper in the resident's shared bathroom the wallpaper border torn off the wall.
-left wall of the bedroom has a piece of wallpaper border approx.6 feet in length that was not removed and painted over. (531)

Res. #11's shared bathroom - drywall ripped by soap dispenser, sink counter stained/worn, back of bathroom doors scarred/scraped as well as door frame.(197)

Res. #16's bathroom the surface of sink counter stained. (197)

Res. #10's shared resident bathroom - sink counter surface is worn and stained. The seal has been worn away on the edge of the counter.(197)

Res. #3's ward room noted south wall below the window large patch of drywall damaged. (531)

Res. #37's room -lower right hand corner of the north wall, drywall heavily scarred, chipped.
-lower half of the north wall black scuff marks, paint chipped.
-telephone jack missing cover, tight to the floor exposed wires.
-ceramic wall in the shared bathroom,the back splash, waist level tiles are broken pieces missing.
-lower left corner of the doorway the trim is detached from the wall
-tile floor in front of the sink 3x1 inch piece of tile missing
-ceiling plaster above the resident's lounge chair note cracked, detached and hanging (2' x 1") (531)

Res. #9's shared bathroom ceramic tile missing from the wall behind the toilet paper holder. (197)

Res. #14's Shared bathroom - sink counter top worn and stained

- drywall ripped off wall above counter,
-inside of bathroom door scarred/scraped, as well as door frame.(197)

Res #5 -multiple permanent blackened scuff marks on the tile floor
- baseboard heater under the window has been damaged, heat shield partially detached. (531)

Resident #27 ‘s shared bathroom observed cracks in wall, holes in ceramic tiles where towel bar used to be, both ends of the towel bar still hanging on wall with no towel bar attached. Some wall tiles chipped behind bathroom door. (197)

Res. # 18’s the shared resident bathroom - sink counter surface is worn and stained. The seal has been worn away on the edge of the counter. (197)

Res #8 and 15’s shared ward room multiple cracks in multiple tiles (covering most of the visible floor surface)
Lower twelve inches of the left wall is scarred gouged, paint missing along the entire length of the wall
-right corner of partial dividing partition between residents is heavily scarred, gouged exposing the corner steel (sharp) bead x 5 feet from the floor exposing the steel corner.
- large black marks the length of the foot board, the flooring tile worn exposing black base of tile, pattern worn off tiles.
-clothes closet doors heavily scarred, gouged
-bi-fold closet door broken/off the track (531)

During the initial tour of the home on February 29, 2016 inspector #531 observed the following:

Main floor dining area:
- inspector observed three 12 X 12 inch flooring tiles in front of the window had been replaced with 1/2' border filled with old glue/dirt debris
-west entrance flooring -4 flooring tiles with multiple cracks and filled with debris.
-flooring tile cracked broken, 2x3 inch piece of tile missing exposing sub floor
-far west wall 4x6 inch piece of flooring tile broken and missing.
-east wall above the chair rail observed a 3'x 6" area of drywall noted heavily scarred, gouged drywall pieces missing and paint chipped /scarred.
-north lower wall lower 10 inches in the centre of the wall approx.15" x2" area drywall gouged and wallpaper missing

-dining chairs noted worn, scarred, chipped/splintered wooden legs
-east doorway refitted , drywall unfinished with sharp

First floor activity/tv lounge:
-ceiling area surrounding center light noted large drywall plaster areas, left side of the light, 4x4 foot unfinished plastered area and 2x4 foot area to the right of the light.
-base board heater below south window noted heat shield cover damaged and detached in the centre and the sharp outside edge hanging. (531)

Second floor:
Dining area:
-4 large tiles noted in the entrance to the dining area with multiple cracks and debris
-lower half of the north wall the entire length of the wall the drywall is scarred, gouged and paint missing
-communal washroom across near the elevators the 3" flooring trim noted detached from the wall in areas
-the elevator door frame plastic type corner protectors large pieces broken , sharp jagged edges on all three floors. (531)

Third floor:
-shower room cracked aged discoloured tiles noted on the right side of the toilet bowl
-corner dividing post the lower 6"x6" ceramic tile surrounding the corner broken, missing half of the ceramic tile, sharp jagged edges.
-dining room , noted two steel dining table legs with visible rust.
- 6 dining dining room chairs  the wooden arms and legs are worn, splintered, heavily chipped.
-3 steel type bi fold chairs legs visibly
-rough splintered table edge (531)

Non-intact and unfinished surfaces cannot be thoroughly cleaned, placing residents at increased risk
for spread of infection.

On March 4, 2016 during an interview with the Administrator and tour of the identified areas of disrepair, she confirmed that the disrepair had been identified, replacement of the dining room chairs has been approved and the identified areas will be prioritized for repair. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring furnishings and equipment have been maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**Issued on this 9th day of March, 2016**

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

**Original report signed by the inspector.**