Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Aug 6, 2020	2020_779641_0021	013522-20	Complaint

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

CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 28, 29, 30, 31, 2020.

This inspection was conducted in reference to complaint intake log #013522-20 related to resident care and staff concerns in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Life Enrichment Supervisor, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Cook, Dietary Aide and residents.
During the course of the inspection, the Inspector reviewed resident health care records, observed resident care, reviewed policies and procedures related to medication administration, nutrition and hydration and staffing plan.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Nutrition and Hydration
Sufficient Staffing

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 failed to ensure that the Director was immediately informed of the unexpected and sudden death of resident #001.

On a specified date, resident #001 passed away suddenly and unexpectedly.

During an interview with Inspector #641 on July 30, 2020, the Director of Care (DOC) advised that the coroner had come in to the home to assess the situation as this had been an unexpected death. When asked by the Inspector why a critical incident report hadn't been sent for this incident, the DOC stated not being aware that one was required.

During an interview with Inspector #641 on July 30, 2020, the Administrator (Admin) indicated not being aware that a critical incident report had been required for this type of incident. The Admin agreed that the death of resident #001 had been sudden and unexpected.

The licensee failed to ensure that a critical incident was submitted to the Director immediately as notification of the unexpected and sudden death of resident #001. [s. 107. (1)]

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.