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

Ottawa District
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Original Public Report

Report Issue Date: May 12, 2023	
Inspection Number: 2023-1074-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: ManorCare Partners	
Long Term Care Home and City: Stirling Manor Nursing Home, Stirling	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.05.12 10:57:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2-5, 2023

The following intake(s) were inspected:

- Intake: #00015232/CIS #2470-000008-22 – regarding a fall with injury requiring transfer to hospital
- Intake: #00017147/CIS #2470-000010-22 - regarding a fall with injury requiring transfer to hospital
- Intake: #00017660 – Anonymous complaint regarding alleged staff to resident verbal abuse and neglect
- Intake: #00086661- Complaint regarding insufficient staffing impacting resident care and services

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The licensee failed to ensure that a long-term care home with a licensed bed capacity of 69 beds or fewer, has an infection prevention and control (IPAC) lead that works regularly in that position on site at the home at least 17.5 hours per week.

Rationale and summary:

In May 2023, the Director of Care (DOC) indicated that there was currently no IPAC lead working in the home and that the legislated requirements for 17. 5 hours per week specific to IPAC was not being met. The Administrator confirmed that they are actively trying to fill this position. In the interim both the DOC and the Administrator are working to fulfill IPAC requirements in the home.

Failing to ensure there is an IPAC lead in the home could result in sub-standard IPAC practices placing residents at risk of contracting infections resulting in illness.

Sources:

Interviews with DOC and the Administrator. [602]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg 246/22 s. 53 (1) 1.

The licensee failed to comply with their written policy related to falls prevention and management for a resident.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their written policy related to falls prevention and management for residents is complied with.

Specifically, staff did not comply with the resident's falls assessment procedure: Commence a head injury routine (HIR) if you suspect the resident has hit his/her head or fall was unwitnessed.

Rationale and Summary:

A resident was found on the floor beside their bed. The Critical Incident System (CIS) report indicated

that it was likely the resident attempted to transfer independently from bed to a standing position. The fall was unwitnessed. An assessment was completed, however, no HIR was initiated.

A subsequent review of the resident's health record found that a HIR was not initiated on four unwitnessed falls for this resident. The DOC and a Registered Nurse (RN) confirmed that a HIR is to be commenced for all unwitnessed falls. The DOC was unable to locate HIR documentation for the four unwitnessed falls.

Failure to complete HIR following unwitnessed falls posed a risk to the resident as they were not monitored for neurological symptoms after sustaining possible head injury(ies).

Sources:
Resident electronic and hard copy health records, CIS report, Falls Investigation and Documentation Policy, interviews with the DOC, RN and the Administrator. [602]