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: August 21, 2023	
Inspection Number: 2023-1074-0004	
Inspection Type: Critical Incident System	
Licensee: ManorCare Partners	
Long Term Care Home and City: Stirling Manor Nursing Home, Stirling	
Lead Inspector Kayla Debois (740792)	**Inspector Digital Signature** Kayla L Debois Digitally signed by Kayla L Debois Date: 2023.08.21 16:02:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11, 2023

The following intake(s) were inspected:

- Intake: #00092077 [CI: 2470-000005-23] - Fall of resident, sustained an injury
- Intake: #00092709 [CI: 2470-000006-23] - Fall of resident, sustained an injury

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

Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required programs

NC #001 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 a resident's falls investigation and documentation policy (#NM F-11, revised October 2022): commence a head injury routine/neurological vital signs record if it is suspected that the resident hit their head or for any unwitnessed fall.

Rationale and Summary:
On a day in July 2023, a resident was found in the hallway outside of their room, lying on their side. According to the progress notes on PointClickCare (PCC), this fall was unwitnessed. The resident was complaining of shoulder pain and was unable to move their arm. The Registered Nurse (RN) completed an assessment and the resident was transferred to hospital.

An electronic and hard copy chart review was completed and no documentation of head injury routine was found.

The Administrator confirmed that a head injury routine is to be commenced for all unwitnessed falls and this should be initiated even if the resident is being sent to hospital.

By not ensuring the written policy related to falls prevention and management was complied with, the resident was at an increased risk of injury.

Sources:
Resident's electronic and hard copy health record, Falls Investigation and Documentation Policy #NM F-11, interview with Administrator.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition no later than one business day.

Rationale and Summary:
On a day in July 2023, a resident sustained a fall and immediately after was unable to move their arm and complained of pain to their shoulder. The resident was sent to the hospital for assessment an hour and thirty minutes later. The next day, it was documented in PointClickCare (PCC) that the resident sustained a fracture of the humeral neck. The resident returned from the hospital two days later, with a sling on their arm and an order for new pain medication.

This incident was reported by the Administrator to the Director six days after the incident occurred. In an interview with the Administrator, they stated that they knew the resident had a fracture the day after they fell, but didn't know what their status would be as they had not yet returned to the home, although they did suspect there would be a change.

A delay in reporting critical incidents to the Director can increase the risk of harm/injury to the resident.

Sources:
Resident's progress notes on PCC, review of CI report #2470-000005-23, interview with Administrator.

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