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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 23, 2024	
Inspection Number: 2024-1074-0001	
Inspection Type: Critical Incident	
Licensee: ManorCare Partners	
Long Term Care Home and City: Stirling Manor Nursing Home, Stirling	
Lead Inspector Carrie Deline (740788)	Inspector Digital Signature Carrie E Deline Digitally signed by Carrie E Deline Date: 2024.04.26 14:29:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16 - 18, 2024

The following intake(s) were inspected:

- Intake: #00112599 - CIS #2470-000005-24 - Fall of resident resulting in injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a residents written plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale & Summary:

On a specific date a resident sustained an unwitnessed fall. The resident was transferred to hospital for treatment of their injuries. A review of the written plan of care in place at the time of the incident found no falls prevention interventions were indicated.

During an interview with a staff member it was stated that the falls prevention information for residents would be in the communication book, the care plan binder at the nursing station, and on a posted sign located in the residents room. An interview with the Director of Nursing (DON) confirmed that the falls prevention information should be in the kardex, care plans, and on the resident safety sheet posted at the nursing station. During an interview with the Administrator it was

confirmed that the resident did not have falls prevention information on their care plan or kardex. The DON was able to provide the inspector with a Resident safety sheet that was posted at the nursing station, with the resident listed on it as requiring falls prevention interventions. Staff were not able to identify that this sheet was a part of the plan of care.

Failure to ensure clear direction of falls prevention interventions could place the resident at an increased risk for falls with injury.

Sources:
Resident progress notes, care plan, falls assessments, residents kardex, resident safety sheets, interviews with Registered staff, personal support worker (PSW), DON, and Administrator.

[740788]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a residents plan of care has been documented.

Rationale and Summary

Review of the resident's plan of care indicated that the resident was to be toileted Q2hours (every two hours).

Review of the Personal Support Worker (PSW) documentation for a one month period, related to toileting for a resident, indicated that documentation was not completed on two shifts in the time period. The Q2hour (every 2 hours) toileting documentation sheets that were separate from the flowsheets were not completed for the one month period reviewed.

During an interview with Inspector #740788 the Director of Nursing (DON) stated that the resident would have been toileted more than every two hours at their request. DON confirmed that toileting documentation was to be completed on separate toileting sheets located in the PSW flowsheet binder. Inspector confirmed with DOC that they were not completed for the period reviewed.

Failing to ensure resident's toileting was documented can increase the risk of uncertainty whether the care was provided or not.

Sources:
Review of the plan of care, the PSW documentation and interview with DOC..

[740788]