Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 26, 29, 30, 2012	2012_049143_0042	Other

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director Of Nursing, a Registered Practical Nurse, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) completed a tour of all resident rooms, reviewed policies and procedures related to bed rails and the use of restraints, reviewed residents plan of care, physician orders and Personal Support Workers flow sheets.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. On October 26, 2012 a review of the home's restraint policy # NM R-37 identified that physical restraints include but not limited to: 3. Bed rails (2 full or 4 half rails) up on both sides. The procedure included the responsibility of the Registered Staff to obtain a signed informed consent, documenting the resident's behavior, documenting alternatives considered, the resident response to the restraint, the physician order stating the type of restraint ordered, how often and by who the restraint is to be applied as well as the monitoring of the resident while restrained. The physician responsibilities included: assessing the resident and provide an order for the type of restraint, reason for restraint and when restraint is to be applied.
It is noted that resident # 3, # 7 and resident # 8 had no physician orders for the application of two full side rails and no documented assessments including the monitoring of these residents while being restraint.
The licensee has failed to ensure that the restraint policy is complied with Long Term Care Homes Act 2007 section 29. (1)(b)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. On October 26, 2012 a review of the use of bed rails in the home and used by residents indicated that Resident # 5 side rails had not been identified as posing an entrapment risk as assessed by Medical Mart during an audit of all bed rails used in the home.
The inspector completed a tour of the home on October 26, 2012 and it was noted that Resident #5 was observed to have a bed that posed a Zone 1 and 2 entrapment risk as per the Health Canada's Guidance Document titled "Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards." It is noted that the recommended distance for Zone 1 and Zone 2 (as per Health Canada Guidance Document) recommended the distance be less then 120 millimeters (4 3/4 inches). It was observed that resident #5 had bed rails identical to resident # 13 which had been identified as posing an entrapment risk. A copy of the homes sales order invoice # 109451 dated October 18, 2012 indicated that bed rail pads had been ordered to manage entrapment risk.
The licensee has failed to comply by not ensuring that all beds rails had been assessed and evaluated to minimize risk to residents as per ON/Regulation 79/10 section 15(1)a.

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 to ensure that all residents are assessed for risk of entrapment when bed rails are used, to be implemented voluntarily.

Issued on this 30th day of October, 2012

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