Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2013	2013_179103_0030	O-000394-13	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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 24, 26, 28, July 15-18, 2013

During the course of the inspection, the inspector(s) spoke with Registered Staff, the RAI coordinator, the Office Manager, the Physiotherapist, the Director of Care, the Administrator and Jane Meadus, a lawyer representing Advocacy Centre for the Elderly (ACE)

During the course of the inspection, the inspector(s) reviewed resident health care records including the 24 hour admission care plan and progress notes, reviewed the following regulated documents: Long Term Care Home Accommodation Agreement, Long Term Care Home Unfunded Services Agreement, Personal Care Consent Form, Medical Plan of Treatment/Personal Care Consent Form, reviewed the lawyer's certification of the aforementioned regulated documents, and reviewed documentation provided to the home by ACE.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Resident Charges

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 24 (2) 1 whereby the risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks were not outlined in the resident 24-hour admission care plan.

Resident #1 was admitted to the home on an identified date. Five days following admission, the resident walked from the bed to the nursing station unassisted, lost his/her balance and fell which resulted in an injury.

S#107 was interviewed and stated it is the home's practice to review the level of mobility and transfer requirements with the resident, the family and the Community Care Access Centre (CCAC) referral at the time of admission and to identify any risks, including risk of falls, on the admission care plan.

The CCAC MDS data, provided to the home, indicated under "Physical functioning": "Client's children report that client inconsistently used a walker prior to his/her hospitalization and has had at least 3 falls in past 90 days"

The 24 hour care plan in effect at the time of the fall was reviewed. It indicated under "mobility": self, weight bearing and unsteady on feet. There was no indication that the resident was at risk for falls and there were no identified interventions to mitigate that risk. [s. 24. (2) 1.]

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 all newly admitted residents with an identified risk of falls have this included in their care plan and any interventions to mitigate the risk, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 80. Regulated documents for resident

Specifically failed to comply with the following:

s. 80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,
(a) the regulated document complies with all the requirements of the regulations; and 2007, c. 8, s. 80. (1).
(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 80 (1) (a) whereby the licensee presented for signature regulated documents that did not comply with all the requirements of the regulations.

Resident #1 was admitted to Stirling Manor on an identified date. The regulated document "Personal Care Consent Form" and Medical Plan of Treatment/Personal Care Consent Form" were presented for signature.

O. Reg 79/10 s. 227 (6) (a), states a document containing a consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a document containing a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, must:
-meet the requirements of that Act, including the requirement for informed consent to treatment under that Act.

"Treatment" under the Health Care Consent Act, 1996 means:
-anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,
(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
(b) the assessment or examination of a person to determine the general nature of the person's condition,
(c) the taking of a person's health history,
(d) the communication of an assessment or diagnosis,
(e) the admission of a person to a hospital or other facility,
(f) a personal assistance service,
(g) a treatment that in the circumstances poses little or no risk of harm to the person,
(h) anything prescribed by the regulations as not constituting treatment.

At the time of Resident #1's admission to the home, at a minimum, the Personal Care Consent Form document on its face did not comply with the Health Care Consent Act, 1996 because:
(a) Alcoholic beverages, closet cleaning, photo consent and off-site outings are not

considered a treatment and do not belong in such a form; and
(b) the request for the signatory to acknowledge that changes in the resident's health status may occur, that the nursing staff may notify the attending physician/facility physicians of such changes and that the physician may change aspects of the plan of treatment, goes beyond the included consent contemplated by s. 12 of the Health Care Consent Act (HCCA), 1996.

The HCCA, 1996 s. 12 states:
Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,
(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and
(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

The home has revised the Medical Plan of Treatment form, however the form continues to include social alcoholic beverages under "Treatment".

O. Reg 79/10 s. 227 (6) (c) and (d) states a document containing a consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a document containing a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, must:
-contain a statement indicating that the consent may be withdrawn or revoked at any time; and
-must set out the text of section 83 of the Act.

LTCHA s. 83 (1) states, "Every licensee of a long term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,
(a) a document has not been signed;
(b) an agreement has been voided; or
(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked."

Both the Medical Plan of Treatment/Personal Care Consent Form and The Personal Care Consent Form documents at the time of Resident #1's admission to the home failed to contain a statement indicating that the consent may be withdrawn or revoked at any time and failed to set out the text of section 83 of the Act. Both forms have since been revised. [s. 80. (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 all regulated documents comply with all the requirements of the regulations, to be implemented voluntarily.

Issued on this 2nd day of August, 2013

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