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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2016	2016_389601_0015	016458-16	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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 28 and 29, 2016.

Related to log #016458-16 regarding resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Physiotherapist, Dietitian, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), a resident and family member.

The Inspector completed a tour of one resident home area, observed resident care and services, reviewed the identified resident's clinical health care record and applicable policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident related to the resident's nutritional and continence care.

Related to log #016458-16:

Resident #001 was admitted to the home dependent on staff for all care and services including nutritional and fluid requirements.

Review of resident #001's most recent care plan identified interventions to maintain nutritional and fluid requirements.

Review of resident #001's clinical records for approximately four months identified that resident #001 had required medical treatment regarding the administration of an identified nutritional supplement on seven identified dates during a four month period.

Review of resident #001's current Medication Administration Records identified:

On an identified date in February 2016, the Dietitian ordered the administration of a nutritional supplement four times a day that was preceded with 50ml of water and followed with 250ml water.

On an identified date in April 2016, the Physician ordered the administration of a nutritional supplement three times a day that was preceded with 50ml of water and followed with 250ml of water.

On an identified date in June 2016, the Physician ordered the following for resident #001: crush medication fine and mix with lots of water before administering; mix the nutritional supplement with the amount of water prescribed to create a more dilute formula; administer at least 60ml of water following the nutritional supplement four times a day.

During an interview on an identified date, RPN #101 indicated to Inspector #601 that the current direction was to administer 50ml of water prior to resident #001's nutritional supplement and follow with 250ml of water. RPN #101 also indicated there was no direction related to the rate to administer nutritional supplement.

During an interview and observation of the administration of the 1200 hour nutritional supplement on an identified date for resident #001, RPN #109 indicated that resident #001's medication was crushed fine, dissolved in 30ml of tap water and administered using an identified method. Following the administration of the medication resident #001 received 50ml of water. RPN #109 indicated that the Physician orders direct to give lots of water when administering the medication but the amount of water required to mix the medication was not provided. RPN #109 indicated there was no direction to the rate the nutritional supplement should be administered. RPN #109 administered 100ml of water and indicated this was done to prevent identified complications. RPN #109 administered another 150ml of water using a different identified method.

During an interview on an identified date, RN #104 indicated that resident #001's had returned from the hospital with a temporary medical treatment in place for an identified six day period starting in March 2016 and for another identified five day period in June 2016 due to the proper medical equipment not being available. RN #104 indicated there were identified complications when administering resident #001's nutritional supplement while the temporary medical equipment was in place. RN #104 indicated the Dietitian had instructed the nurses to administer the nutritional supplement by an identified method. During an interview on an identified date, RN #104 indicated the current direction was to administer resident #001's 50ml of water by an identified method prior to the nutritional supplement and 250ml of water by the same identified method following the nutritional supplement.

Review of resident #001's progress note documented by RN #104 on an identified date in March 2016 indicated that resident #001 had received nutritional supplement by an identified method due to identified complications with the temporary medical treatment in place.

Review of documentation completed on an identified date by RN #104 in the nurse's communication book, indicated that the Dietitian had said that resident #001's daytime nutritional supplement can be given over fifteen minutes using an identified method. Monitor for identified complications; for the 500ml nutritional supplement the Dietitian recommends giving 250ml; wait thirty minutes and then give 250ml again.

During an interview on an identified date, the Dietitian indicated that temporary measures had been put into place to administer resident #001's nutritional supplement by a different identified method when resident #001 had a temporary medical treatment in place.

During an interview on an identified date, the Director of Nursing indicated the Dietitian directs the nurses related to the administration of nutritional supplements and the directions placed in the communication book on the identified date should have been transcribed on resident #001's Physician Order Form to ensure the nurses had clear direction. The Director of Nursing also indicated that the nurses should have clarified resident #001's order with the Physician or Dietitian to receive clear direction related to the rate the nutritional supplement should have been administered and the amount of water to be administered prior and following the identified nutritional supplement.

2. Review of resident #001’s clinical records for a four month period identified that resident #001 had received medical treatment related to continence care on three identified dates.

According to the hospital discharge summary report resident #001 was transferred to the hospital on an identified date in May 2016 following an identified nursing intervention that resulted in a medical condition that required immediate medical treatment.

Review of resident #001's physician order regarding the specialized urinary continence treatment was not individualized for resident #001 to provide the nurse clear direction. Review of resident #001’s progress notes identified that on the identified date in May 2016, RPN #110 provided the specialized urinary treatment prior to obtaining the individualized direction from the Physician. Resident #001 developed identified complications following the specialized urinary treatment and was transferred to the hospital for immediate medical treatment.

Review of the homes Policy #NM C-25 related to specialized urinary continence management directs that registered nurses and registered practical nurses may provide the identified treatment only with a physician's order that has the identified interventions.

During an interview, the Director of Nursing indicated the nurses should have clarified resident #001's specialized urinary continence order with the Physician to receive clear direction prior to providing the identified treatment.

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 the plan of care for resident #001 sets out clear direction to staff and others who provide direct care to the resident related to the residents nutritional and continence care, to be implemented voluntarily.

Issued on this 3rd day of August, 2016

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

Original report signed by the inspector.