Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 20, 2022
Inspection Number 2022_1074_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
ManorCare Partners

Long-Term Care Home and City
Stirling Manor,
Stirling, Ontario

Lead Inspector
Darlene Murphy (103)

Inspector Digital Signature
Darlene Murphy
2022.05.20 14:55:30 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 10, 11, 16, 2022.

The following intake(s) were inspected:

- Log #002309-22 and Log #007614-22-complaints related to resident care,
- Log #007806-22 (CIS #2470-000002-22)-resident fall that resulted in injury.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

WRITTEN NOTIFICATION PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (5)
The licensee has failed to ensure the resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
An RPN stated they were responsible for contacting the resident's Power of Attorney (POA) to obtain consent for the administration of a vaccine. The RPN indicated in error, they contacted a family member that did not hold the POA for care for one of the residents. Subsequently, the resident's POA was uninformed of and did not provide consent for the administration of the vaccination.

Sources:
Interview with an RPN and a resident health care record.