

**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: (877) 779-5559  
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<b>Original Public Report</b>	
<b>Report Issue Date:</b> January 9, 2023	
<b>Inspection Number:</b> 2022-1074-0002	
<b>Inspection Type:</b> Complaint Critical Incident System	
<b>Licensee:</b> ManorCare Partners	
<b>Long Term Care Home and City:</b> Stirling Manor Nursing Home, Stirling	
<b>Lead Inspector</b> Kayla Debois (740792)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Wendy Brown (602)	

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):  
November 30, December 1, 2, and 5-8, 2022

The following intake(s) were inspected:

- Intake: #00006194-[CI: 2470-000006-22] Fall of resident, sustained an injury
- Intake: #00006345- Concerns regarding skin and wound management, medication management
- Intake: #00012442- Concerns regarding nursing and personal support services

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

Falls Prevention and Management  
Resident Care and Support Services  
Infection Prevention and Control  
Medication Management

Skin and Wound Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is point-of-care signage indicating that enhanced IPAC control measures are in place.

#### Rationale and Summary:

On two separate dates, the Inspector observed no additional precautions signage outside of a resident room who was on additional precautions. In interviews with staff members, they stated that the resident was on precautions and there should be a sign outside of the room.

Failing to ensure appropriate signage is used for residents on additional precautions increases the risk of transmission of infectious agents and can result in illness to the residents.

**Sources:** Interviews with staff members.

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Non-compliance with: O. Reg. 246/22 s. 102 (2) (b).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that additional PPE requirements including appropriate selection and application is followed.

#### Rationale and Summary:

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The Inspector observed a staff member wearing a surgical mask for PPE when providing care to a resident on droplet precautions. While interviewing the staff member, they stated that if a resident is on droplet precautions, a gown, mask with eye protection, and gloves should be worn while in the room. Inspector observed that there were no PPE easily accessible to staff on the floor. Staff members stated that PPE is stocked by housekeeping and should be in a bin outside of the resident's room. Another staff member stated they stock the PPE for resident rooms that are on precautions in the bins outside the door and the PPE is stored in the pandemic supply storage room on the first floor. The Inspector observed that there were no bins outside of the resident rooms on additional precautions.

Failing to ensure appropriate PPE is worn for residents on additional precautions increases the risk of transmission of infectious agents and can result in illness to the residents.

**Sources:** Interviews with staff members.

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**WRITTEN NOTIFICATION: Infection prevention and control program**

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

The licensee has failed to ensure that a long-term care home with more than 69 beds but less than 200 beds has an infection prevention and control (IPAC) lead that works regularly in that position on site at the home at least 26.25 hours per week.

**Rationale and Summary:**

A management team member identified themselves as the IPAC lead for the home and indicated they worked approximately two and a half days (eighteen hours) per week in that role.

**Sources:**

Observations on multiple units, and interviews with management team members.

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**WRITTEN NOTIFICATION: Skin and wound care**

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

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Non-compliance with: O. Reg. 79/10, s. 50 (2) (a) (ii).

The licensee has failed to ensure that a wound assessment was completed for a resident after re-admission from hospital.

**Rationale and Summary:**

A resident had a wound before being admitted to the home.

On a day in May 2020, the resident was sent to the hospital because of an infected wound. The resident returned from the hospital in June 2020. The progress note created on that day indicated that the resident's dressing was to be changed the next day. Three days later, it was documented that there was a very strong, foul smell coming from the wound. The physician was notified that the dressing had not been removed and the wound had not been assessed. The resident was sent to hospital that day and required surgical intervention.

A staff member stated that upon the return of a resident from hospital, a wound assessment should be completed. The Inspector reviewed the resident's wound assessments on PointClickCare (PCC) and the paper copy of the 'Pressure Ulcer/Wound Assessment Record'. An assessment of the dressing, but not the wound, was completed upon return from hospital. There were no wound assessments completed. Staff members stated visualizing the dressing is not an appropriate wound assessment and the dressing should have been removed. A staff member confirmed there was no wound assessment completed for the resident after re-admission from hospital in June 2020.

Not completing a wound care assessment poses a risk to the resident in that their altered skin integrity is not being assessed after returning from hospital which could result in a deterioration of the area.

**Sources:** Interview with staff members, resident's progress notes, PointClickCare Weekly Wound Assessment 2.0, Pressure Ulcer/Wound Assessment Record.

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**WRITTEN NOTIFICATION: Skin and wound care program**

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to comply with their written protocol related to skin and wound care.

In accordance with O. Reg. 246/22 s. 11 (1) b., the licensee is required to ensure that their protocol

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related to skin and wound care is complied with.

Specifically, staff did not comply with the communication procedure 'Clarification from RCC, July 6th, 2022' for referring new or concerning wounds to the wound care nurse.

**Rationale and Summary:**

The inspector reviewed the procedure 'Clarification from RCC, July 6th, 2022' in the 'RCC Communication Book'. This stated that new or concerning wounds that are not healing or are infectious are to be noted in this book for the wound care nurse to see.

A staff member stated that a resident's wound on their buttock was not communicated in the 'RCC Communication Book', so they were not aware of the wound until it had worsened. The staff member also stated they were not notified in the 'RCC Communication Book' of three other resident's new wounds that occurred in December 2022.

When asked about the wound referral process, a staff member stated the wound care nurse would be notified by the wound binder or the nurses' daily communication binder. Another staff member stated if there were a new wound, they would initiate an assessment in the wound binder, on PCC, and communicate this to the next nurse on shift. They stated if they had a concerning wound to be assessed by the skin and wound nurse, they would ask the charge nurse about the process. The staff members did not mention the 'RCC Communication Book' for the referral process.

A member of the management team stated that it is the expectation that staff follow the steps outlined in the 'RCC Communication Book' to refer a wound to the wound care nurse.

Not communicating new or worsening wounds may result in deterioration and/or lack of treatment of resident's wounds.

**Sources:** Interview with staff members, interview with a management member, 'Clarification from RCC, July 6th, 2022' procedure in the 'RCC Communication Book'.

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**WRITTEN NOTIFICATION: Falls prevention and management program**

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with their written policy related to falls prevention and management for a resident.

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In accordance with O. Reg. 246/22 s. 11. (1) b, the licensee is required to ensure that their written policy related to falls prevention and management for a resident is complied with.

Specifically, staff did not comply with the resident's falls assessment procedure (#NM F-11, revised October 2017): commence a head injury routine (HIR)/neurological vital signs record following any unwitnessed fall.

**Rationale and Summary:**

On a day in August 2022, a resident was found on the floor. A member of the management team completed an assessment and found no obvious injury. When staff transferred the resident to bed, they complained of pain in their leg. Another staff member completed an assessment and the resident was transferred to hospital for possible fracture. An electronic and hard copy chart review was completed and no documentation of neurological vital signs/head injury routine (HIR) was found. A member of management confirmed that a HIR is to be commenced for all unwitnessed falls as residents are to be monitored for neurological symptoms after possibly sustaining a head injury.

This posed a risk to the resident as they were not monitored for neurological symptoms after sustaining a head injury.

**Sources:** Resident's electronic and hard copy health record, Falls Investigation and Documentation Policy # NM F-11 revised October 2017, interviews with management and other staff members.

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