

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 16, 2024	
Inspection Number: 2024-1074-0003	
Inspection Type: Critical Incident	
Licensee: ManorCare Partners	
Long Term Care Home and City: Stirling Manor Nursing Home, Stirling	
Lead Inspector Stephanie Fitzgerald (741726)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, 12, 15, 16, 2024.

The following intake(s) were inspected:

- Intake: #00119258 - CI #2470-000008-24 - fall resulting in injury.
- Intake: #00119949 - CI #2470-000009-24 - fall resulting in injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that two residents were reassessed, and their plan of care reviewed and revised when their care needs changed, after sustaining a fall with injury in June, 2024.

Sources: Resident's care plans, CI # 2470-000008-24, CI # 2470-000009-24,
Interviews with multiple staff, and RAI #104 [741726]

WRITTEN NOTIFICATION: Required programs

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

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

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Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that their written policy related to falls prevention and management was complied with, for two residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with:

- Falls Risk Assessment Policy #NM F-5: Staff failed to complete a Falls Risk Assessment Tool (FRAT) on both of the residents quarterly, and as their condition changes.
- Falls Investigation and Documentation Policy #NM F-11: Staff failed to commence the Head Injury Routine for resident #001, when they sustained an unwitnessed fall.

Sources:

Progress Notes, , physical chart for resident #001; FRAT History for both residents, CI #2470-000008-24, CI #2470-000009-24, Falls Risk Assessment Policy #NM F-5, Falls Investigation and Documentation Policy #NM F-11, Interviews with RN, RAI #104, Administrator #100. [741726]