

**Ministry of Health
and Long-Term Care**

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

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**Ministère de la Santé
et des Soins de longue durée**

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
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OCT 27 2010

Ms. Charmaine Jordan
Administrator
Stirling Manor
218 Edward St., P.O. Box 220
Stirling ON K0K 3E0

Dear Ms. Jordan:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on August 12 – 13, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,


Darlene Murphy
LTC Home Inspector – Nursing

- c President, Resident's Council
- President, Family Council



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

**Rapport d'inspection
prevue le *Loi de 2007
les foyers de soins de
longue durée***

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Licensee Copy/Copie du Titulaire



Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection

August 12 and 13, 2010

**Inspection No/
d'inspection**

2010_103_2470_12Au
g112230

Type of Inspection/Genre d'insptection

Complaint
Log # O-000794

Licensee/Titulaire

ManorCare Partners, 6257 Main St., Stouffville, ON L4A 4J3 Fax# 905-640-4772

Long-Term Care Home/Foyer de soins de longue durée

Stirling Manor, 218 Edward St., P.O. Box 220, Stirling, Ontario K0K 3E0

Name of Inspector(s)/Nom de l'inspecteur(s)

Darlene Murphy (ID#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint inspection related to wound and skin care assessment.

During the course of the inspection, the inspector spoke with: 1 Registered Practical Nurse, 2 Registered Nurses, RAI Coordinator, Director of Care, and the Administrator.

During the course of the inspection, the inspector reviewed one resident health record.

The following Inspection Protocols were used in part or in whole during this inspection:

- Hospitalization and Death Inspection Protocol
- Skin and Wound Inspection Protocol

15 Findings of Non-Compliance were found during this inspection. The following action was taken:

8 WN
4 VPC
3 CO: CO # 001, #002, #003

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de la Loi de 2007 sur les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 sur les foyers de soins de longue durée* à trouvé. (Une exigence dans la loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

WN#1: The Licensee has failed to comply with: LTCHA, 2007, S.O 2007, c.8, s.3(1)8

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. Personal Support Worker (PSW) was assisting a resident in the bathroom that is located off a main hallway on Floor #2. The bathroom door was not closed instead, a privacy curtain, suspended on a rod was pulled across the doorway. The conversation between the PSW and the resident in regards to personal needs were clearly audible to anyone walking through the hall.

VPC-pursuant to LTCHA, 2007, S.O 2007 c.8 s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that all residents are afforded privacy during care. This plan is to be implemented voluntarily.

Inspector ID#: 103

WN#2: The Licensee has failed to comply with: LTCHA, 2007, S.O 2007, c.8, s.6(1)(c)

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
- (b) the goals the care is intended to achieve; and
- (c) clear directions to staff and others who provide direct care to the resident

Findings:

1. The progress notes indicate an air boot was being utilized for pressure reduction for a resident wound; the plan of care did not include instructions for the air boot in regards to how or when to apply or remove.
2. The progress notes indicate a resident should not "apply a lot of pressure" to the area of the wound; the plan of care did not provide staff with directions on transfers to minimize pressure to affected area.
3. There were no directions to staff in the plan of care in regards to the treatment and containment of the condition of the resident's wound
4. The plan of care indicated there was skin breakdown of a resident's right shin; the actual source of the

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Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de la Loi de 2007 sur les foyers de soins de longue durée.

Non-respect avec les exigences sur la *Loi de 2007 sur les foyers de soins de longue durée* à trouvé. (Une exigence dans la loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

open area was the heel.

5. The plan of care did not identify or provide instructions to staff concerning treatment for open wounds on a resident identified in July 24, 25, 2010 progress notes

VPC-pursuant to LTCHA, 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 plans of care for residents with skin and wound impairments provide staff with clear directions for all aspects of resident care needs identified. This plan is to be implemented voluntarily.

Inspector ID#: 103

WN#3: The Licensee has failed to comply with: LTCHA, 2007, S.O 2007, c.8, s.6(10)(b)

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,

- (a) a goal in the plan is met,
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or
- (c) care set out in the plan has not been effective

Findings:

1. Personal Support Workers (PSW) document the presence of foul odor coming from a resident wound on June 29/10; the Registered staff documented on the wound sheet on June 29/10 that the loose dressing was reinforced with tape; there was no indication of reassessment by a registered staff member related to the presence of odor
2. A residents wound showed clinical signs (ie. Wound base has black eschar, drainage is foul smelling, peri wound skin is red and macerated) of deterioration on July 11, 2010, but there is no indication of reassessment until 10 days later on July 21/10 when the physician ordered a change in treatment.
3. Resident wound continued to deteriorate (foul smelling drainage and black eschar on wound base) after the change in treatment; July 25/10, the peri wound skin was noted to be pink and warm to touch; there was no indication of a reassessment of treatment at that time until the physician saw on July 28/10 and an oral antibiotic and daily dressing changes were ordered.
4. The status of the resident wound from July 28-Aug 2/10 (6 days) showed no improvement on the antibiotic. On July 31/10, registered staff charted in the progress notes that the wound is "blackened and odorous"; "will wait until resident sees dermatologist on Aug 5/10".

Inspector ID#: 103

Compliance Order #001 will be served on the Licensee.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de la Loi de 2007 sur les foyers de soins de longue durée.

Non-respect avec les exigences sur la *Loi de 2007 sur les foyers de soins de longue durée* à trouvé. (Une exigence dans la loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#4: The Licensee has failed to comply with: LTCHA, 2007, S.O 2007, c.8, s.6(4)(a)

The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

- (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and**
- (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.**

Findings:

1. On June 18, 2010, a resident wound opened. According to the progress notes charted by registered nursing staff, the wound was draining copious amounts of sero-sanguinous fluid into towels that were being changed every 1-2 hours. This change in condition was not communicated to the attending physician until June 23, 2010. During that time period, the wound was noted to deteriorate.

Inspector ID#: 103

Compliance Order #002 will be served on the Licensee

WN#5: The Licensee has failed to comply with: O. Reg. 79/10 s.50(2)(b)(i)

Every licensee of a long-term care home shall ensure that,

- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
- (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.**

Findings:

1. Progress notes on July 24/10 and July 25, 2010 indicate a resident had an open area on the upper right buttock; a viscopaste dressing was applied; there was no indication of a documented wound and skin assessment by the registered staff on either date.
2. July 31, 2010, Personal support workers (PSW) notes from evenings indicate a resident has a "very red" inner left ankle; there is no documented evidence of a wound and skin assessment by registered staff.
3. Aug.2/10, PSW notes on evenings indicate the presence of an open wound on a resident coccyx; there is no documented wound and skin assessment by the registered staff.

VPC-pursuant to LTCHA, 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 staff are doing skin and wound assessments on all residents with altered skin integrity. This plan is to be implemented voluntarily.

Inspector ID#: 103

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#6: The Licensee has failed to comply with: O. Reg. 79/10 s. 50(2)(b)(iv)

Every licensee of a long-term care home shall ensure that,

- (b) resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
- (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically needed**

Findings:

1. No documented assessment done by registered staff on a resident wound from June 30/10 until July 11/10; wound base on June 30/10 was described as "pink"; wound base on July 11, 2010 described as black eschar, peri-wound is red and macerated and the drainage is noted to be foul smelling.
2. No documented assessment by registered staff on a resident wound on the coccyx/buttocks area from July 13/10 until noted by Registered nurse when doing post hospitalization skin check on Aug 4, 2010.

Inspector ID#: 103

Compliance Order #003 will be served on the Licensee

WN#7: The Licensee has failed to comply with: O. Reg. 79/10 s. 52(1)4

(1) The pain management program must, at a minimum, provide for the following:

4. Monitoring of resident's responses to, and the effectiveness of, the pain management strategies

Findings:

1. A resident received Tylenol #3 on 6 occasions in May/10 and the effectiveness of the medication was indicated only 1 out of the 6 times.
2. A resident received Tylenol #3 on 10 occasions in July/10 and the effectiveness of the medication was indicated only 5 out of 10 times.
3. A resident received Tylenol #3 on 5 occasions in Aug/10 and the effectiveness of the medication was indicated only 3 out of 5 times.

VPC-pursuant to LTCHA, 2007, S.O 2007 c.8 s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring a process is in place for the ongoing monitoring of resident pain following the administration of analgesics. The plan is to be implemented voluntarily.

Inspector ID#: 103

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#8: The Licensee has failed to comply with: O. Reg. 79/10 s.27(1)(a)

Every licensee of a long-term care home shall ensure that,

- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker

Findings:

- 1. A care conference was not held for a resident within six weeks of his admission.

Inspector ID#: 103

Signature of Licensee of Designated Representative
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Oct 6/10 Darlene Murphy

Title:

Date:

Date of Report (if different from date(s) of inspection).

