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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2013	2013_228172_0011	L-000245-13	Critical Incident System

Licensee/Titulaire de permis

SPRUCEDALE CARE CENTRE INC
96 KITTRIDGE AVENUE EAST, STRATHROY, ON, N7G-2A8

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

SPRUCEDALE CARE CENTRE
96 KITTRIDGE AVENUE EAST, STRATHROY, ON, N7G-2A8

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

JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 4, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, 1 Registered Practical Nurse, and 2 Personal Support Workers

During the course of the inspection, the inspector(s) made observations, reviewed health care records and the home's Fall prevention program

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

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 the plan of care gives clear direction to staff providing direct care to a resident.

Observations revealed a fall prevention strategy has been implemented for a specific resident.

Interviews with 2 Personal Support Workers and the Director of Care revealed a fall prevention strategy for a specific resident had been implemented.

A care plan review revealed no reference to this fall prevention strategy.

Interview with the Director of Care verified the fall prevention intervention was not documented in the care plan and should be. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that controlled substances are stored in a separate double-locked stationary cupboard in the locked or stored in a separate locked areas within the locked medication cart.

Observation of a medication cart revealed it was unlocked, unattended and the narcotic drawer was not locked.

The unlocked cart, was shown to the registered staff by the Inspector, who then closed the narcotic drawer lid completely so it locked.

The Director of Care confirmed the home's expectation is that the medication cart and the narcotic drawer will be locked when not attended. [s. 129. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The Licensee has failed to ensure all areas where drugs are stored are kept locked at all times when not in use.

Observation of a medication cart revealed it was unlocked, and unattended

The Director of Care confirmed the home's expectation is that the medication cart will be locked when not attended. [s. 130. 1.]

Issued on this 26th day of June, 2013

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

Joan L. Woodley R.N.