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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2019	2019_538144_0028	009817-19, 011966-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

CAROLEE MILLINER (144)

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 24, 2019.

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The following intakes were inspected within this inspection:
Log 009817-19, CIS 2904-000011-19 related to falls prevention and management
Log 011966-19, CIS 2904-000013-19 related to security of drug supply.

During the course of the inspection, the inspector(s) spoke with one resident, one family member, the Administrator, Assistant Director of Care, the Physiotherapist, one Registered Nurse and one Personal Support Worker.

During the course of the inspection, the inspector reviewed one resident clinical record, the home's management of controlled drugs policy and toured three resident home areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 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 drugs were stored in an area or a medication cart that was secured and locked.

CI 2904-000013-19 was reviewed by the inspector and included that during a monitored medication count in one resident home area, one controlled substance medication card was missing from the narcotic bin in the medication cart.

The Administrator and Assistant Director of Care (ADOC) shared with the inspector that during the home's investigation of the incident, the following information was confirmed:

The Registered Practical Nurse (RPN) working on the date of incident had possession of the medication cart and medication cart keys for the entire shift.

During shift change, the monitored medication count completed by one Registered Nurse (RN) and one RPN revealed the number of remaining narcotic tablets on one medication card for a specific resident.

The Registered Nurse (RN) on the shift prior to the incident had possession of the medication cart and medication cart keys for the entire shift.

On the date of incident during another shift change, one RN and one RPN completed the controlled substance and narcotic count for one resident home area and discovered that

there was one medication card missing.

A thorough search of the medication cart and resident home area was completed by staff on site on the unit however, the medication card was not found.

The RN working the oncoming shift on the date of incident notified the Administrator and the Ontario Provincial Police (OPP) of the medication discrepancy then directed all staff to remain in the building until the OPP arrived.

The Administrator obtained witness statements from four personnel that had worked on the date of incident.

The home's investigation further revealed that one identified RN on one recognized shift had left the medication cart unlocked and unattended for an approximated period of time.

At the time of the inspection, the home had not concluded their internal investigation into the incident and had not received follow up from the OPP concerning their investigation. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 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 that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

Issued on this 26th day of June, 2019

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

Original report signed by the inspector.