Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 28, 2011	2011_072120_0033	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care regarding the safe storage of vaccines. (H-002121-11)

During the course of the inspection, the inspector(s) reviewed several policies and procedures on the safe storage of drugs, confirmed the existence of a small refrigerator in the medication room and reviewed the new refrigerator specifications which has been ordered for the home.

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. [O. Reg. 79/10, s.8(1)(b)] The licensee did not ensure that staff complied with their policies and procedures relating to safe vaccine storage and handling.

According to the home's policy V3-1220 titled "Medications - Storage and Safety", (instituted in 1999 and revised in September 2008 and 2010), the "Director of Care will ensure the storage and safe keeping of medications according to policies and procedures".

Policy V6-340 titled "Vaccine Storage and Handling" states that "temperatures must be maintained between 2C and 8C at all times and that they be "checked and recorded twice daily". For the months between August and December 2010, staff failed to take temperatures of the refrigerator on 59 occasions, and therefore the temperature of the refrigerator and vaccine was unknown.

The registered staff between August and December 2010 did not follow the policy and procedure and the Director of Care at the time did not ensure that staff were following the policies.

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 subsections:

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
(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. [O. Reg. 79/10, s.129(1)(a)(iii)& (iv)] The licensee did not ensure that vaccine was protected from heat in order to maintain efficacy and the licensee did not ensure that staff complied with manufacturer's instructions for the storage of the vaccine.

Although the home did not have any vaccines on the premises at the time of inspection, the Director of Care confirmed that registered staff were not taking refrigeration temperatures consistently and that the refrigerator was not suitable for the temperature requirements of the vaccine. As a result, the Brant County Health Unit ceased providing vaccine to the home in early 2011.

Influenza vaccine was being stored by the licensee in a small "bar refrigerator" in 2010. Refrigeration temperature logs were completed by the licensee and monitored by the Brant County Health Unit. These logs were reviewed and confirm that refrigeration temperatures were recorded to be above the manufacturer's specifications of 8C. For the months of August and September 2010, staff failed to keep the refrigerator between 2 and 8C, as required by the manufacturer on 58 occasions. The failure to adequately monitor vaccine storage requirements resulted in the disposal of 10 doses of vaccine on August 31, 2010.

Issued on this 9th day of December, 2011

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

B. Smith