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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 8, 2015	2015_299559_0014	T-725-14	Critical Incident System

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

ANN HENDERSON (559)

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 23, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, acting director of care (DOC), co- director of care (co-DOC), staff educator #2, registered practical nurse (RPN) and personal support worker (PSW).

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 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 failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date, the co-DOC and clinical pharmacist during the process of medication destruction discovered drugs were missing from the discarded drug storage cupboard on an identified home area. A review of a root cause analysis conducted and interviews with RPN #102, #106 and the co- DOC revealed the original drug storage cupboard was not secure.

The co-DOC, RPN #102, and RPN #106, revealed the cupboard had two doors and a padlock applied through the door handles. The co-DOC revealed the padlocked doors could be pulled forward and he/she was able to put half a hand into the space at the top of the door and the medications could be accessed from the opening at the bottom.

RPN #102, revealed the slot in the door where the discarded medication cards were put through was positioned low on the door. Staff interviews further revealed drug destruction was completed less frequently and the medication cards fell directly to the floor of the cupboard near the lower part of the door and the medications could be accessed from the opening at the bottom.

On completion of the home's investigation the co-DOC indicated the drug storage was relocated, the slot was positioned higher up in the right hand door and the left door had been secured to the cupboard frame. A container has been placed inside the cupboard and the discarded medication cards fall directly into the container and drug destruction is now completed weekly.

The acting DOC confirmed the storage cupboard was not secure and the missing drugs were not found. [s. 129. (1) (a)]

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Issued on this 30th day of July, 2015

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

Original report signed by the inspector.