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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
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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
Jan 23, 2014	2013_109153_0028	T-498-13	Follow up

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 2, 3, 4, 10, 16, 2013.

During the course of the inspection, the inspector(s) spoke with Acting Director of Nursing(DON), Nurse Managers, Registered Nurses(RN), Registered Practical Nurses(RPN), Support Assistant.

During the course of the inspection, the inspector(s) reviewed home policy and procedures related to the storage of medications.
Completed observations of who has access to and where medications are stored throughout 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 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 drugs are stored in an area or medication cart that is secure and locked.

a) On December 2, 2013 at 0840 the inspector observed the door to the 5th floor treatment room to be unlocked and to contain 2 treatment carts which were also unlocked.
One treatment cart was for the C side and 1 treatment cart was for the West side. Both contained topical prescription medications.
On the C side treatment cart there was writing from a black marker indicating, "please don't lock cart". Interview with the RN on 5th floor indicated the treatment carts on 5th floor do not lock. The RN locked the treatment room door and indicated the issue would be reported to the Nurse Manager. The lock on the C side treatment cart was engaged and found to be operable.

b) On December 2, 2013 at 0855 on 3rd floor, the inspector observed that the treatment room door was unlocked and 2 unlocked treatment carts containing topical prescription medications were observed inside the room. The inspector reported the situation to the Acting Nurse Manager who indicated she thought the treatment room door automatically locked when the door was closed. When she realized a key was required to lock the door she went and asked a RPN to lock the door.

c) On December 2, 2013 at 1525 the treatment room door on 5th floor was observed to be unlocked and to contain 2 unlocked treatment carts with topical prescription medications. The RN was informed and confirmed the door should be locked and

immediately secured the treatment room door.

d) On December 3, 2013 at 0755 on 4th floor the door to the medication room was ajar. The medication cart in the medication room was unlocked. There was no staff in the medication room or in the hallway outside the medication room. The situation was reported to a registered staff member in the nurses' station who went and closed the door to the medication room.
The inspector checked and the door was locked.

e) On December 3, 2013 at 0805 on the 6th floor the treatment room door was observed to be ajar and contained an unlocked treatment cart for the West side with topical prescription medications.
The inspector observed a bottle of Canestin Cream 1% labeled for an identified resident sitting on a shelf in the treatment room with personal care supplies. The situation was discussed with the 6th floor RN who confirmed the treatment room door should have been closed and secure. The RN obtained a key from the RPN on the C side and locked the treatment room door.

f) On December 4, 2013 at 1435 on 5th floor the inspector observed the medication room door to be ajar and noted the 2 medication carts in the medication room were unlocked and there was no registered staff in attendance.
The situation was reported to the Acting Nurse Manager who was passing by the door. The Acting Nurse Manager met with the RPN who had left the door open to provide direction regarding the need to ensure medications are stored in an area that is secure and locked.
He confirmed when interviewed the medication room door should have been locked and secure.

g) On December 10, 2013 at 1010 on the 7th floor the inspector observed a contractor adjusting the lock on the treatment room door. The door was open and the room contained 2 unlocked treatment carts with topical prescription medications for C side and West side residents. There was no staff in the area. The situation was reported to the Nurse Manager who remained in attendance until the contractor completed the work on the treatment room lock.

h) On December 16, 2013 at 1430 the inspector observed the door to the 5th floor treatment room to be ajar. There was no registered staff in the room. The unlocked treatment carts containing topical prescription medications for the C side and West

side residents were parked in the treatment room that was unlocked. The situation was reported to 2 RPNs who were sitting in the computer room on 5th floor. A RPN proceeded to the 5th floor treatment room and closed the door and made sure it was secure.

When interviewed the DON confirmed all areas of the home where medications are stored are to be secure and locked. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 130.	CO #010	2013_103193_0008	153

Issued on this 24th day of January, 2014

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

Lynn Parsons

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNN PARSONS (153)
Inspection No. / No de l'inspection :	2013_109153_0028
Log No. / Registre no:	T-498-13
Type of Inspection / Genre d' inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 23, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CASTLEVIEW WYCHWOOD TOWERS 351 CHRISTIE STREET, TORONTO, ON, M6G-3C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Lew

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_103193_0008, CO #009;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked.

The plan must be submitted to M.Lynn.Parsons@ontario.ca by January 31, 2014.

Grounds / Motifs :

1. The licensee failed to ensure drugs are stored in an area or medication cart that is secure and locked.

a) O. Reg 79/10 s.129 (1) (a) (ii) was previously issued as a Compliance Order for inspection # 2013_103193_008, issued July 5, 2013.

b) On December 2, 2013 at 0840 the inspector observed the door to the 5th

floor treatment room to be unlocked and to contain 2 treatment carts which were also unlocked.
One treatment cart was for the C side and 1 treatment cart was for the West side. Both contained topical prescription medications.
On the C side treatment cart there was writing from a black marker indicating, "please don't lock cart". Interview with the RN on 5th floor indicated the treatment carts on 5th floor do not lock. The RN locked the treatment room door and indicated the issue would be reported to the Nurse Manager. The lock on the C side treatment cart was engaged and found to be operable.

c) On December 2, 2013 at 0855 on 3rd floor, the inspector observed that the treatment room door was unlocked and 2 unlocked treatment carts containing topical prescription medications were observed inside the room. The inspector reported the situation to the Acting Nurse Manager who indicated she thought the treatment room door automatically locked when the door was closed. When she realized a key was required to lock the door she went and asked a RPN to lock the door.

d) On December 2, 2013 at 1525 the treatment room door on 5th floor was observed to be unlocked and to contain 2 unlocked treatment carts with topical prescription medications. The RN was informed and confirmed the door should be locked and immediately secured the treatment room door.

e) On December 3, 2013 at 0755 on 4th floor the door to the medication room was ajar. The medication cart in the medication room was unlocked. There was no staff in the medication room or in the hallway outside the medication room. The situation was reported to a registered staff member in the nurses' station who went and closed the door to the medication room.
The inspector checked and the door was locked.

f) On December 3, 2013 at 0805 on the 6th floor the treatment room door was observed to be ajar and contained an unlocked treatment cart for the West side with topical prescription medications.
The Inspector observed a bottle of Canestin Cream 1% labeled for an identified resident sitting on a shelf in the treatment room with personal care supplies. The situation was discussed with the 6th floor RN who confirmed the treatment room door should have been closed and secure. The RN obtained a key from the RPN on the C side and locked the treatment room door.

g) On December 4, 2013 at 1435 on 5th floor the inspector observed the medication room door to be ajar and noted the 2 medication carts in the medication room were unlocked and there was no registered staff in attendance.

The situation was reported to the Acting Nurse Manager who was passing by the door. The Acting Nurse Manager met with the RPN who had left the door open to provide direction regarding the need to ensure medications are stored in an area that is secure and locked.
He confirmed when interviewed the medication room door should have been locked and secure.

h) On December 10, 2013 at 1010 on the 7th floor the inspector observed a contractor adjusting the lock on the treatment room door. The door was open and the room contained 2 unlocked treatment carts with topical prescription medications for C side and West side residents. There was no staff in the area. The situation was reported to the Nurse Manager who remained in attendance until the contractor completed the work on the treatment room lock.

i) On December 16, 2013 at 1430 the inspector observed the door to the 5th floor treatment room to be ajar. There was no registered staff in the room. The unlocked treatment carts containing topical prescription medications for the C side and West side residents were parked in the treatment room that was unlocked. The situation was reported to 2 RPNs who were sitting in the computer room on 5th floor. A RPN proceeded to the 5th floor treatment room and closed the door and made sure it was secure.

When interviewed the DON confirmed all areas of the home where medications are stored are to be secure and locked.
(153)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of January, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNN PARSONS

Service Area Office /
Bureau régional de services : Toronto Service Area Office