



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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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
Dec 5, 2013	2013_102116_0064	T-538-13	Other

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

EAGLE TERRACE  
329 EAGLE STREET, NEWMARKET, ON, L3Y-1K3

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

SARAN DANIEL-DODD (116)

**Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct an Other inspection.

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Programs Manager, Registered Staff, Personal Support Workers, Dietary staff, Housekeepers, Resident Council President and Residents.

During the course of the inspection, the inspector(s) reviewed the health record of a resident, observed staff to resident interactions and lunch meal service.

The following Inspection Protocols were used during this inspection:

Dining Observation



Residents' Council

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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :



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1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

The following areas were observed:

- Two wheelchair footrests were observed on the floor outside of a soiled utility room.
- A mop and pail containing water was observed to be stored in an identified hallway outside of an identified resident room. Interview held with housekeeping staff member confirmed that the mop and pail should not be left unattended [s. 5.]

2.

- Tub room door was observed to be left unlocked and ajar. The inspector was able to open and enter the tub room that contained personal care items and wound treatment supplies.
- Interview held with a Manager confirmed that the door must be kept closed and locked at all times. In the event that the door is left open there is to be a grey baby gate preventing access to the room. The gate was observed stored in the right hand corner adjacent to the tub.
- The washroom door behind a nursing station was observed to be left open. The inspector observed a wheelchair footrest lying on the floor. Interview with Registered staff confirmed the washroom is dedicated to an identified resident room and used by residents [s. 5.]

***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 the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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



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**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).**
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**Findings/Faits saillants :**



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

- The treatment cart on an identified unit was observed to be unlocked and stored in an unlocked storage cabinet in the hallway. The treatment cart contained prescribed ointments, creams and wound care supplies. Interview with Registered staff confirmed that the treatment cart should be locked at all times when unattended [s. 129. (1) (a) (ii)]

2. The licensee failed to ensure that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart.

- On a specified date, the inspector observed an open ampoule that contained a controlled substance for Resident #1 stored in the medication bin.

- Interview held with the Registered staff member assigned to the medication cart informed the inspector that the ampoule was opened and administered to Resident #1 over the course of an identified night shift and will be discarded once finished [s. 129. (1) (b)]

3. Interview held with the Director of Care confirmed that all controlled substances once opened are to be used and discarded of within the shift they are opened and are to be double- locked at all times [s. 129. (1) (b)]

***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 medication cart that is secure and locked and that all controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**



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**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

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**Findings/Faits saillants :**

1. The licensee failed to respond in writing within 10 days of receiving concerns from the Resident's Council.

Interviews held with both the Resident Council President and Programs Manager confirmed that the licensee does not respond in writing within 10 days of receiving concerns from the Resident's Council. [s. 57. (2)]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

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**Findings/Faits saillants :**

1. The licensee failed to seek out the advice of the Resident's Council in developing and carrying out the satisfaction survey.

The licensee has not involved the Resident's council in developing and carrying out the satisfaction survey as confirmed by both the Programs Manager and Resident's Council President [s. 85. (3)]



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Issued on this 5th day of December, 2013

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

A handwritten signature in black ink, appearing to read "M. [unclear]". The signature is written in a cursive style within a rectangular box.