Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
609 Kumpf Drive, Suite 105
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Telephone: 1-888-432-7901
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Original Public Report

Report Issue Date September 12, 2022
Inspection Number 2022_1410_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Steeves & Rozema Enterprises Limited

Long-Term Care Home and City
St. Andrew's Terrace Long Term Care Community, Cambridge

Lead Inspector
Robert Spizzirri (705751)

Additional Inspector(s)
Henry Chong (740836)

Inspector Digital Signature
Robert Spizzirri
Digitally signed by Robert Spizzirri
Date: 2022.09.12 09:06:37 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following dates: August 23-25, 29-31, and September 1-2, 2022.

The following intake(s) were inspected:

- Intake # 014694-22 (Complaint) related to fall prevention and management
- Intake # 012997-22 (Critical Incident) related to fall prevention and management
- Intake # 015190-22 (Critical Incident) related to fall prevention and management
- Intake # 012949-22 (Complaint) related to abuse, infection prevention and control, fall prevention and management, skin and wound, and responsive behaviours.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION [INVOLVEMENT OF RESIDENT, ETC.]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (5)

The licensee has failed to ensure that when a resident fell, the substitute decision-maker was given an opportunity to participate in the planning and implementation of their plan of care.

A resident was witnessed falling.

The substitute decision-maker was not informed until two days after.

The resident was later admitted to the hospital with injuries related to the fall.

According to the home's policy, Falls Prevention and Management (May 18, 2022), the resident and/or SDM will be included in post fall management.

Registered staff said that the family should be notified on the same day, and if not possible, within 24 hours.

There was risk as the resident's family was not able to fully participate in the resident's plan of care in response to the fall.

Sources: Resident's progress notes, LTCH's investigation notes, Prevention and Management Program Policy (May 18, 2022), interview with registered staff and other staff.

[740836]

WRITTEN NOTIFICATION [TRANSFERRING AND POSITIONING TECHNIQUE]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting a resident.

A resident was assisted with a transfer by a staff member. The resident was unable to maintain their balance and slid to the floor.

The staff member said that the resident held onto a support that was not considered to be safe.

Two staff stated that the resident should have used the bars next to the toilet when transferring and positioning.

A physiotherapist stated that transfer was not completed safely.

There was injury to resident when staff used unsafe transfer and positioning technique.

Sources: Interviews with staff and interview with physiotherapist.

[740836]

WRITTEN NOTIFICATION [POLICY TO PROMOTE ZERO TOLERANCE]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 25 (1)

The licensee has failed to ensure that their policy to promote zero tolerance of abuse was complied with.

An inspector informed the Manager of Resident Care (MORC) that there was a complaint which included an allegation of abuse.

The complainant indicated that they had made the MORC aware immediately, and that they believed no action had been taken.

a) According to the home's policy, Resident Abuse and Neglect (April 11, 2022), any employee who has knowledge of an incident that constitutes resident abuse or neglect, will intervene, and implement strategies to ensure the safety of every resident.

The MORC said safety measures include immediately asking the alleged abuser to leave the home pending investigation.

The alleged abuser was not asked to leave the home immediately.

The MORC said they did not implement safety measures immediately.

There was risk to the resident's well-being when the home had failed to put safety measures in place immediately.

Sources: Resident Abuse and Neglect Policy (April 11, 2022), home's visitor logs, interviews with Manager of Resident Care, and other staff.

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b) According to the home's policy, Resident Abuse and Neglect (April 11, 2022), the Charge Nurse/Delegate will check the resident's condition to assess his/her safety, emotional, and physical wellbeing, and implement actions as required.

The MORC said assessments include skin, pain, and resident's demeanor, and that they were to be completed immediately.

There was no assessment of the resident completed when the home was notified of the alleged incident of abuse.

The MORC said the assessments were not completed.

There was risk when the home failed to complete their immediate assessment to determine if there was impact to the resident's well-being.

Sources: Resident Abuse and Neglect Policy (April 11, 2022), resident's progress notes and assessments, interviews with Manager of Resident Care, and other staff.

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c) According to the home's policy, Resident Abuse and Neglect (April 11, 2022), the Administrator, MRC or delegate must inform the substitute decision-maker, or other person(s) of significance to the resident of the incident and the current status of the resident, and immediate action(s) taken to ensure the safety of the resident.

The SDM was not notified until eight days after the home was aware of the allegation.

The MORC stated they are to notify SDM's immediately if there are allegations of abuse; however, they wanted to investigate first to determine if there was any merit to the allegation.

There was risk to the resident as the SDM was not able to immediately respond to the allegations and advocate for the resident's safety.

Sources: Resident's progress notes, Resident Abuse and Neglect Policy (April 11, 2022), interviews with Manager of Resident Care and other staff.

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WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 28 (1) 2

The licensee has failed to ensure that when they had reasonable grounds to suspect a resident had been abused, that it was immediately reported to the Director.

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A staff member witnessed an incident that they suspected to be abuse. They said they had informed the Manager of Resident Care (MORC) immediately.

The MORC said they were not made aware until the Inspector informed them of the allegation.

The home reported the incident to the Director eight days after being made aware.

The MORC said that they did not report it immediately.

Failure of the home to immediately report the incident could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical incident report, interviews with Manager of Resident Care, complainant, and other staff.

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