Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 5, 2025

Inspection Number: 2025-1410-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Steeves & Rozema Enterprises Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28-31, 2025, and February 3, 2025.
The inspection occurred offsite on the following date(s): January 28, 2025 and February 4, 2025.
The following intake(s) were inspected:

- Intake: #00133122, related to prevention of abuse,
- Intake: #00134790, Follow-up Order #001 related to infection prevention and control,
- Intake: #00136437, related to infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1410-0006 related to O. Reg. 246/22, s. 102 (9)

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Pursuant to s. 154 (3) of the Fixing Long-term Care Act, 2021, where an inspector finds that a staff member was vicariously liable with subsection 28 (1), the licensee shall be deemed to have not complied.

The licensee has failed to ensure that when two staff members had reasonable grounds to suspect abuse of a resident resulting in harm, the information was immediately reported and the information upon which it was based to the Director.

Sources: Critical Incident (CI) report, interviews with an RPN and a Manager of Resident Care (MRC).

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident sustained an injury, they received a skin assessment using a clinically appropriate instrument that is specifically designed for skin and wound assessments. Despite staff having known about the injury, an assessment was not completed until a later day.

Sources: PointClickCare (PCC) Skin assessments, interviews with an RPN and an MRC.

WRITTEN NOTIFICATION: POLICE NOTIFICATION

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

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute

a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that when an MRC became aware of an incident of abuse of a resident by staff that may constitute a criminal offence, the appropriate police service was immediately notified.

Sources: CI report, "Resident Abuse and Neglect" policy, interview with an MRC.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to ensure that when they received a written complaint concerning the care of a resident, that the follow-up response included the date by which the complainant could reasonably expect a resolution.

Sources: CI report, a complaint response letter, and interview with an MRC.

WRITTEN NOTIFICATION: COMPLAINTS - REPORTING CERTAIN MATTERS TO DIRECTOR

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 111 (2)

Complaints — reporting certain matters to Director

s. 111 (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director.

Pursuant to section 111 (1), every licensee who receives a written complaint with respect to a matter that the licensee reports under section 28 of the Act, shall submit a copy of the complaint to the Director along with a written response the licensee made to the complaint under subsection 108 (1).

The licensee has failed to ensure compliance with subsection (1) when they did not submit a copy of the written response made to the complainant to the Director, immediately upon completing the licensee's investigation.

Sources: CI report and interview with an MRC.

COMPLIANCE ORDER CO #001 Duty to Protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
a) Re-educate the staff on the home's policies and protocols related to resident abuse and neglect. This must include a review on the different types of abuse and the staff's role and responsibilities for reporting and responding to alleged, suspected, and witnessed incidents of abuse and neglect.

b) A record of the education provided must be kept in the home. The record must include all materials reviewed, the date(s) the education was provided and completed, the name(s) of the individual(s) who provided the education, and signed by the staff.

Grounds
The licensee has failed to ensure that a resident was protected from abuse by two staff members.

"Physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Two staff members applied physical force towards a resident, while another staff member provided care resulting in injuries.

The resident's family member visited and reported the injuries to a nurse. The resident expressed to the family member that their injuries were a result of being forced to do something they did not want to do.

Despite one of the staff members having witnessed the incident and the nurse becoming aware of the injuries, measures were not immediately taken to ensure the

safety and protection of the resident. The incident was not immediately reported, the resident was not immediately assessed, and there were no interventions to remove the staff members involved, until the resident's family member informed the home.

Sources: CI report, LTCH's Investigation notes, interviews with the resident's family member, a nurse, and an MRC.

This order must be complied with by March 19, 2025.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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