Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2021	2021_876606_0019	009574-21	Complaint

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 Sarnia ON N7T 7X1

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

St. Andrew's Terrace Long Term Care Community
255 St. Andrew's Street Cambridge ON N1S 1P1

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 27, 30, 31, September 1-3, 2021, and September 8, 2021, (off-site).

The following intake was completed in this complaint inspection:
Log #009574-21 concerns related to a resident's medication, nutrition and hydration, personal support services and skin and wound care management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MOC), Assistant Manager of Resident Care (AMOC), Registered Dietitian (RD), Nurse Practitioner (NP), Manager of Environmental Services (MES), Rehabilitation Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Housekeeping, PSW Students, Substitute Decision Makers(SDM), and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure a resident was provided with the appropriate mobility aide and pressure relieving device to meet the resident's health condition.

A staff reported the pressure relieving device from a resident's mobility aide was damaged. Later, the resident was identified with an area of impaired skin integrity which worsened.

A Registered Practical Nurse (RPN) said they were informed that the resident's pressure relieving device was damaged. They provided the resident with another mobility device that had a pressure relieving device.

The RPN said the mobility aide the resident sat in was bigger than the one they previously used and allowed the resident to move side to side. The impaired skin integrity the resident developed may have been caused by the resident moving side to side in the mobility device. The Nurse Practitioner (NP) assessed the resident's impaired skin integrity and felt it may have developed due to shearing of the skin.

The Home's Rehabilitation Coordinator acknowledged that the replacement mobility aide and pressure relieving device the resident used were not appropriate for them.

Failing to provide the resident with a mobility aide and pressure relieving device that fit them properly may have been a factor in the resident developing an impaired skin integrity.

Sources: resident's care plan, skin assessments, and interviews with staff. [s. 30. (1) 2.]

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 Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident’s condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Home's Infection Prevention and Control Program.

During a snack service, a Personal Support Worker (PSW) assisted four residents with their snacks, handled dirty dishes and glasses and did not perform hand hygiene. The PSW acknowledged this.

During a meal service observation on a Resident Home Area (RHA), staff did not offer or assist 13 residents with hand hygiene before and after they finished their meals.

The Infection Control Lead said staff were expected to offer and assist residents with hand hygiene before and after meals.

Failure to complete hand hygiene increased the risk of infection transmission and could have put residents, staff and others at potential risk of harm.

SOURCES: Observations and interviews with staff. [s. 229. (4)]

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 the licensee shall ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.3) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and O. Reg. 79/10, s. 20 (1.3).
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

Findings/Faits saillants :

1. The licensee has failed to ensure that heat related illness prevention and management plan for the home was implemented yearly during the period of May 15 to September 15.

Review of an identified Home's document did not show that air temperatures were recorded as required. The Manager of Environmental Services (MES) acknowledged the Home had not initiated the heat related illness prevention and management plan as required by the legislation.

SOURCES: A Home's policy and procedure and an interview with the Home's MES. [s. 20. (1.3) (a)]

Issued on this 5th day of October, 2021

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

Original report signed by the inspector.