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

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Original Public Report

Report Issue Date June 29, 2022

Inspection Number 2022_1410_0001

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

Romela Villaspir (653)

Inspector Digital Signature

Romela Villaspir
Romela Villaspir
2022.06.30
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Additional Inspector(s)

Nuzhat Uddin (532)

Parimah Oormazdi (741672) and Maya Kuzmin (741674) were present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 26-27, 30-31, June 1-3, 6-10, 2022.

The following intake(s) were inspected:

Log #006380-22 was related to refusal of admission.
Log #009032-22 was related to an allegation of improper care and neglect of a resident.
Log #008960-22 was related to an injury of unknown cause.
Log #002860-22 was related to an unexpected death of a resident.
Log #003693-22 was related to falls prevention and management.

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

- Resident Care and Support Services
- Residents' Rights and Choices
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

A Personal Protective Equipment (PPE) caddy was parked outside of a resident's room but there was no additional precautions signage posted at the entrance of the room.

Eight days later, an additional precautions signage was posted by the registered staff at the entrance of the resident's room.

Sources: Inspector #532 and #653's observations; Interviews with the Infection Prevention and Control (IPAC) Lead, and other staff.

Date Remedy Implemented: June 3, 2022 [532]

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22 s. 115 (1) 5

An Acute Respiratory Illness (ARI) outbreak was declared by Public Health on a Home Area (HA).

The IPAC Lead of the home did not immediately submit a Critical Incident (CI) report for the confirmed ARI outbreak, as they had initially thought that CI reports would only be submitted for COVID-19 outbreaks.

The IPAC Lead submitted a CI report to the Ministry of Long-Term Care (MLTC) for the ARI outbreak, three days after it was declared by Public Health.

Sources: CI report; Interview with the IPAC Lead.

Date Remedy Implemented: June 10, 2022 [653]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22 s. 102 (9) (a)

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with the IPAC standard issued by the Director under subsection (2).

Rationale and Summary

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 3.1 (b) and (f), the licensee shall ensure that the following surveillance actions are taken: Ensuring that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs) and ensuring that surveillance information is tracked and entered into the surveillance database and/or reporting tools.

A) The home's policy titled "Resident Screening and Surveillance" directed staff to ensure that:

- on every shift daily symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol.
- on every shift symptoms are recorded and immediate action is taken to reduce transmissions and isolate residents and place them in cohorts as required.

A Registered Practical Nurse (RPN) stated that the registered staff used to complete the line listing to document the presence of infection. However, the registered staff were not monitoring or recording the symptoms of infection for the residents. They took action after the resident presented with symptoms of infection. The RPN further indicated that daily temperature checks for the residents were not being completed or recorded.

The IPAC Lead stated that they used to have a surveillance sheet in each home area to track infections but recently the registered staff were not completing the tracking sheet as required.

The IPAC Lead also acknowledged that the staff were not taking the residents' temperatures as part of the daily monitoring of COVID-19 symptoms since March 1, 2022.

Sources: Resident Screening and Surveillance policy #ICM 02-22 last revised on May 19, 2022; Interviews with a RPN and the IPAC Lead. [532]

WRITTEN NOTIFICATION: CMOH AND MOH

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

Non-compliance with: O. Reg. 246/22 s. 272

The licensee has failed to ensure that Directive #3 was followed in the home.

Rationale and Summary

A) Directive #3 required LTCHs to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, including for outdoor visits. Homes must follow the Ministry of Health's COVID-19 screening tool for LTCHs and Retirement Homes (RHs), effective March 18, 2022, or as current, for minimum requirements and exemptions regarding active screening.

As per the screening tool, homes were required to maintain visitor logs of all visits to the home, and the visitor log must include, at minimum, the name and contact information of the visitor, and the purpose of the visit (e.g. name of resident visited).

During the duration of the inspection from May 26, to June 10, 2022, the inspectors' contact information were not taken by the screener upon entry.

The IPAC Lead acknowledged that the home's visitor log did not include a section for the visitor's contact information and purpose of the visit.

B) Directive #3 required LTCHs to ensure that physical distancing (a minimum of 2 metres or 6 feet) is practiced by all individuals at all times, except for the purposes of providing direct care to a resident, and other exceptions indicated in the COVID-19 guidance document for LTCHs in Ontario.

During separate observations conducted by Inspector #653 in all HAs, it was noted that a number of residents were not physically distanced in the common areas.

Separate interviews with a RPN, Registered Nurse (RN), and the IPAC Lead indicated that residents were encouraged to practice physical distancing, however, it can be challenging to maintain it at times.

Sources: Inspector #653's observations; COVID-19 Directive #3 for LTCHs under the Fixing Long-Term Care Act, 2021, issued May 3, 2022, Ministry of Health's COVID-19 screening tool for LTCHs and RHs Version 10 – March 18, 2022, the home's active screening visitor log; Interviews with a RPN, RN, and the IPAC Lead. [653]

WRITTEN NOTIFICATION: AUTHORIZATION FOR ADMISSION TO A HOME

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

Non-compliance with: LTCHA, 2007 s. 44 (7)

The licensee has failed to comply with s. 44 (7) of the Long-Term Care Homes Act (LTCHA) whereby the licensee refused the application of an applicant for reasons other than provided for in the LTCHA.

Rationale and Summary

The MLTC received a complaint related to the home withholding approval for admission of an applicant.

The Waterloo Wellington Local Health Integration Networks (LHIN) referred the applicant to St. Andrew's Terrace LTC for a long stay admission, and basic accommodation.

The applicant's health profile indicated they exhibited responsive behaviours.

The placement coordinator received a message from the home to proceed with the applicant's admission offer. However, 8 days later, the home's interim Manager of Resident Care (iMRC) withdrew the bed offer after receiving further information regarding the applicant's responsive behaviours.

The placement coordinator stated there were no changes to the applicant's responsive behaviours from the time the application was accepted until the time the bed offer was withdrawn by the home.

The home cited LTCHA, 2007, s. 44 (7) (c) as being their ground for withholding approval, and O. Reg. 79/10, s. 54.

As per record reviews and staff interviews, there was not enough information to substantiate that circumstances existed which were provided for in the regulations as being a ground for withholding approval of the applicant's admission to the home. The home had a responsive behaviours management program, and under the program, behavioural triggers were assessed, strategies were created, and interventions were implemented to manage residents' responsive behaviours. The home also provided education, training, an in-service on responsive behaviours management to staff upon hire and annually thereafter. External resources such as the Psychogeriatric Resource Consultation (PRC) and Geriatric Psychiatrist were also available if needed.

The applicant continued to remain at the hospital due to the home's refusal of their admission.

Sources: Applicant's assessments, the home's written notice; Interviews with the placement coordinator, iMRC; Administrator; and the Resident Assessment Instrument (RAI)-Minimum Data Set (MDS) Co-ordinator. [653]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 93 (2) (b) (ii)

The licensee has failed to ensure that a resident's wheelchair was cleaned and disinfected.

Rationale and Summary

According to the home's policy titled "Cleaning and Disinfection", weekly and as needed cleaning and disinfection of wheelchairs will be completed by team members following the recommendations of the manufacturer product instructions, and ensure documentation is completed.

On two different dates, Inspector #653 observed a resident sitting in their wheelchair that was unclean.

A Personal Support Worker (PSW) and RPN confirmed that the resident was not included in the HA's wheelchair cleaning schedule on paper and on Point of Care (POC).

Sources: Inspector #653's observations; Cleaning and Disinfection policy #ICM 02-03, revised May 17, 2022, HA's wheelchair cleaning schedule on paper and POC; Interviews with PSW, RPN, and the iMRC. [653]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 18

The licensee has failed to ensure that a resident's right to be afforded privacy in treatment and in caring for their personal needs, was fully respected and promoted by an Agency RPN.

Rationale and Summary

An Agency RPN changed a resident's wound dressing in a common area. There were about 12 other residents in the same area.

The Assistant Manager of Resident Care (AMRC) indicated that dressing changes must be done in the resident's room to maintain privacy.

Sources: Inspector #653's observation; Resident's electronic Treatment Administration Record (eTAR); Interviews with Agency RPN, and the AMRC. [653]

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (1)

The licensee has failed to ensure that a resident's bedroom was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary

The home's air temperature records showed that on May 18, 2022, the air temperatures in a resident's room from 0100 hours (hrs) to 2300 hrs, ranged from 17.5 to 21.5 degrees Celsius.

By not maintaining the air temperature at a minimum temperature of 22 degrees Celsius in the resident's room, there was a risk that the resident may have felt uncomfortable and cold inside their bedroom.

Sources: Home's Alert labs air temperature records; Interview with the Manager of Environmental Services Department (MESD). [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident complained of new pain, and for 6 consecutive days, the resident's pain was assessed as moderate to severe pain based on their pain scale rating. As needed pain medication was administered to the resident, however, it was ineffective in relieving their pain.

The AMRC and the iMRC indicated that if the resident's pain was not relieved and they continued to experience pain even after receiving standard and as needed pain medications, the on-call physician or the nurse practitioner should have been notified by the registered staff.

By not informing the on-call physician or the nurse practitioner about the resident's continuous pain, further assessments and interventions to address the resident's pain were not provided in a timely manner.

Sources: Resident's clinical health records; Interviews with a RPN, AMRC, and the iMRC. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident, collaborated with each other in the development and implementation of the plan of care as it related to falls interventions, so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident had a fall and was sent to hospital for further assessment. A RN completed a fall risk screening assessment post fall and documented their recommendations for falls interventions which included the use of a device. The RN indicated they recommended the falls intervention, however, it would have been the nurse re-admitting the resident from the hospital, who would have implemented it. The device was not added to the resident's care plan, and it was not implemented.

Seventeen days later, the resident had another fall, and at the time of the incident, the resident did not have the device in place. The resident was sent to hospital for further assessment, and was diagnosed with an injury.

By the registered staff not collaborating with each other in the development and implementation of the resident's plan of care, a falls prevention intervention was not implemented for the resident.

Sources: Resident's clinical health records; Interviews with a PSW, RN, and a Resident Care Coordinator (RCC). [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's written plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A resident had responsive behaviours, and their care plan identified a specific intervention to be implemented.

Inspector #653 observed that the intervention was not implemented, and the Behavioural Support Ontario (BSO) PSW confirmed that the intervention was supposed to be in place as part of the resident's responsive behaviour interventions.

Sources: Inspector #653's observation; Resident's clinical health records; Interview with BSO PSW. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (11) (b)

The licensee has failed to ensure that different approaches were considered in the revision of a resident's plan of care as it related to falls interventions.

Rationale and Summary

A resident had an unwitnessed fall and was sent to hospital for further assessment. Upon return to the home, falls interventions were revised and implemented.

However, in spite of these new interventions, the resident continued to be at risk for falls and had 8 subsequent falls within a 4-month period.

A PSW indicated that the resident would get agitated at times and it could be due to needing a brief change. The PSW confirmed that the resident did not have a toileting schedule in place.

The home's policy titled "Prevention and Intervention of Falls" identified altered elimination as one of the causes for falls, and the intervention was to assess and develop an individualized toileting routine.

The RCC indicated that a toileting routine could definitely be explored for the resident as a falls intervention.

Sources: Resident's clinical health records, Prevention and Intervention of Falls policy #RCM 10-02-01B revised on May 18, 2022; Interviews with a PSW, and the RCC. [653]

WRITTEN NOTIFICATION: PASDS THAT LIMIT OR INHIBIT MOVEMENT

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 36 (4) 1

The licensee has failed to ensure that alternatives to the use of a Personal Assistance Service Device (PASD) have been considered, and tried where appropriate, by completing a restraint/ or PASD assessment and alternatives as per the home's policy.

Rationale and Summary

The home's policy titled "Minimizing of Restraining: Use of Restraints, Confinement and Use of PASD" indicated that a restraint/ or PASD assessment and alternatives will be completed in Point Click Care (PCC).

Inspector #653 observed a resident with a device applied to them. Staff indicated that the resident was not capable of removing the device on their own. As per the resident's written plan of care, the device was used as a PASD.

The RCC reviewed the resident's clinical health records and confirmed there was no assessment completed specific to the device use, and that the home's policy required the completion of a Restraint/ or PASD Assessment prior to its application.

By not completing an assessment, the resident's condition, circumstances or clinical indicators and other alternatives may not have been considered prior to the use of a PASD.

Sources: Inspector #653's observation; Minimizing of Restraining: Use of Restraints, Confinement and Use of PASD policy #RCM 10-08 last revised on April 12, 2022; Interviews with a PSW, RPN, and the RCC. [653]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A resident complained of new pain, and for 6 consecutive days, the resident's pain was assessed as moderate to severe pain based on their pain scale rating. As needed pain medication was administered to the resident, however, it was ineffective in relieving their pain. A pain assessment tool was not completed by the registered staff for the resident.

The AMRC indicated that when the resident's new pain was not relieved by initial pain interventions, the clinically appropriate pain assessment instrument should have been completed on PCC.

By not using a clinically appropriate assessment instrument for pain, in assessing the resident when their pain was not relieved by initial interventions, the effectiveness of the pain interventions provided to the resident was not evaluated, and the goals for pain management may not have been achieved.

Sources: Resident's clinical health records; Interviews with a RPN, AMRC, and the iMRC. [653]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Rationale and Summary

The home submitted a CI report to the MLTC related to an allegation of resident-to-resident abuse.

On an identified date and time, a physical altercation occurred between two residents. No injuries were sustained.

A resident was identified to have responsive behaviours, and their clinical health records showed there were five documented incidents of altercation with co-residents prior to the abovementioned incident.

As a result of these five documented incidents, assessments were initiated, however, interventions were not identified and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

By not taking steps to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, the incidents between the residents continued to occur until the home put in place an intervention for the resident following the sixth incident of altercation.

Sources: Residents' clinical health records; Interviews with the BSO PSW, Former BSO RPN, RCCs, and the AMRC. [653]