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
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Original Public Report

Report Issue Date: December 5, 2022	
Inspection Number: 2022-1410-0003	
Inspection Type: Critical Incident System	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: St. Andrew's Terrace Long Term Care Community, Cambridge	
Lead Inspector Amanpreet Kaur Malhi (741128)	**Inspector Digital Signature** Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2022.12.05 15:47:58 -05'00'
Additional Inspector(s) Kristen Owen (741123)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 23, 2022 - November 25, 2022, and November 29, 2022

The following intake(s) were inspected during this Critical Incident (CI) inspection:

- Intake #00002168 related to staff to resident neglect.
- Intake: #00011841 related to resident-to-resident abuse.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Infection Prevention and Control

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 #1 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 27 (2)

The licensee failed to report the home's investigation results in regard to a critical incident (CI) submitted related to alleged neglect of a resident. The home completed an internal investigation. The home's Manager of Resident Care and Assistant Manager of Resident Care stated that they did not update the CI with the results of the home's internal investigation.

Later that day, CI was updated with the home's completed analysis and follow-up actions.

Sources: CI report, LTCH's investigation notes, Resident's clinical records, and Interview with home's Manager of Resident Care

Date Remedy Implemented: November 29, 2022

[741128]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected from abuse by another resident.

Section 2 (1) (c), of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

Rationale and Summary

Staff observed a resident becoming physically responsive towards another resident. Staff stated they intervened.

As a result of the physical abuse, one resident sustained injuries.

Sources: CI report**,** LTCH's investigation notes, resident's clinical records, and interviews with staff.

[741123]

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