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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 3, 2023

Inspection Number: 2023-1410-0004

Inspection Type:
Complaint
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	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2023.05.05 14:33:43 -04'00'

Additional Inspector(s)
Robert Spizzirri (705751)
Kaitlyn Puklicz (000685)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-6, 11, 12, 2023

The following intake(s) were inspected:
• Intake: #00017771 related to resident to resident physical abuse.

• Intake: #00020088 [Complaint] Concerns regarding responsive behaviors, plan of care, and wound care.

• Intake: #00020602 related to resident to resident physical abuse.

• Intake: #00021240 related to falls prevention and management.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

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 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
At the time of inspection, there was no falling leaf logo present on a resident's doorframe as indicated in the resident's plan of care.

A staff member said that the falling leaf logos occasionally go missing or are taken down by other residents. The staff member said that the resident should have a falling leaf logo on their doorframe.

The next day, a falling leaf logo was observed on the resident's doorframe.

When the falling leaf logo was missing from the resident's doorframe, there was a potential risk of staff not being aware that this resident was high risk for falls.

Sources: observations of a resident's doorway, a resident's plan of care, interviews with staff.

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Date Remedy Implemented: April 6, 2023

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

The licensee has failed to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone has occurred, resulting in harm or risk of harm to the resident, that it was reported immediately to the Director.

Rationale and Summary:
A) A resident reached out causing a skin tear to another resident.

The Director was notified of the incident the next day. A staff member said that the incident should have been reported immediately to the Director but was not.

Sources: CI 2926-000006-23, interviews with staff.

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B) Staff observed an incident where a resident hit another resident.

The Director was notified of the incident the following day.

A staff member stated that the incident should have been reported immediately because there was risk of harm at the time of the incident.

Sources: CI 2926-000008-23, interviews with staff.

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C) An incident occurred where a resident pushed another resident which resulted in a fall. The incident was immediately reported to the on-call manager. The resident who fell was assessed and redness was noted.

The Director was notified of the incident the following day.

A staff member stated that the incident should have been reported immediately because there was risk of harm at the time of the incident.

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

Sources: CI 2926-000003-23, interviews with staff.

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WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen, the resident was assessed and where the condition of the resident requires, a post-fall assessment was conducted using an appropriate form that was specifically designed for falls.

Rationale and Summary:
A resident had an unwitnessed fall resulting in an injury. A post falls assessment was not completed following their fall.

A staff member said that a post falls assessment should have been completed following the resident's fall, but it was not.

By failing to ensure that a post-falls assessment was completed following the resident's fall, there was a risk of not identifying and treating potential injuries because of the fall.

Sources: a resident's assessment tab in Point Click Care (PCC), interviews with staff.

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WRITTEN NOTIFICATION: General Requirements for Programs

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that when any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Rationale and Summary:
A resident demonstrated responsive behaviours. The Dementia Observation System (DOS) assessments were implemented to assist team members to understand the cause(s) of their responsive behaviours, and to track the patterns of these behaviours and develop appropriate interventions.

Documentation on the DOS was incomplete for several dates for three months.

A staff member acknowledged the gaps in documentation and said that staff were expected to complete it each shift.

When staff do not complete the required documentation on the DOS, it reduces the home's ability to track patterns and develop appropriate interventions.

Sources: a resident's DOS records, interviews with staff.

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WRITTEN NOTIFICATION: Behaviours and Altercations

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure procedures and interventions to assist residents and staff who are at risk of harm as a result of behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents were implemented.

Rationale and Summary:
One to one (1:1) staff monitoring was implemented at all times (24/7) for a resident due to their responsive behaviours which put themselves and others at risk of harm.

A staff member said that the role of the 1:1 was to monitor the resident and redirect them if they are

becoming or at risk of becoming agitated.

A 1:1 staff member was assigned to monitor a resident. That day, there was yelling heard and another staff member responded. They observed the resident who was assigned the 1:1 grab another resident and push them, resulting in the resident falling.

A staff member reviewed the camera footage of the incident and noted that the 1:1 who was scheduled, assisted the resident but then left to attend to other residents. The 1:1 was not observing the resident at the time of the incident.

The staff member said that the 1:1 was expected to stay with the resident and/or report and switch with another team member if they were leaving.

Failure to ensure 1:1 was implemented as intended put other residents at risk of harm.

Sources: a resident's progress notes, internal investigation notes, interviews with staff.

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