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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Original Public Report

Report Issue Date: May 27, 2024	
Inspection Number: 2024-1410-0002	
Inspection Type: Critical Incident	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: St. Andrew's Terrace Long Term Care Community, Cambridge	
Lead Inspector Diane Schilling (000736)	**Inspector Digital Signature** Diane Schilling Digitally signed by Diane Schilling Date: 2024.05.30 09:35:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, 2024, May 1-2 & 6, 2024

The following intake(s) were inspected:

- Intake: #00112008 - 2926-000025-24 related to an allegation of resident abuse

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to comply with their policy for zero tolerance of abuse and neglect.

Rationale and Summary

The LTCH's policy, "Resident Abuse and Neglect," contains procedures about responding with zero tolerance to any incidents of abuse or neglect.

The LTCH responded to an incident of abuse of a resident. Two assessments were not completed as required.

There was a risk of an injury not being detected when staff failed to respond as required.

Source: Resident's clinical record, interviews with MRC and other staff. [000736]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

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

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

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee failed to implement interventions to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary

A resident was observed to be without their required support on three occasions.

Behaviour Supports Ontario (BSO) lead stated that the resident should always have their needed support in place and that other residents are at risk without that support.

Residents are at risk when needed support was not in place for the resident.

Sources: Resident's clinical records, interviews with BSO lead and others [000736]

WRITTEN NOTIFICATION: Behaviours and altercations

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

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to comply with their procedures following a responsive behaviour incident with a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that following an incident of responsive behaviour, a review of the incident was completed and documented in the progress notes.

Specifically, staff did not comply with the policy, "Responsive behaviour" revised May 20, 2022. There was missing information in the resident's progress notes about the responsive behaviour incident.

The Manager of Resident Care stated that the registered staff should have completed the review and documentation required.

There is a risk that information about the responsive behaviour incident will not be known by other staff when this information is not fully documented in the progress notes.

Sources: Resident #001 clinical record, interview with MRC.
[000736]