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

Original Public Report

Report Issue Date: July 8, 2024

Inspection Number: 2024-1410-0003

Inspection Type:
Complaint
Critical Incident

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: 2024.07.10 09:56:07 -04'00'

Additional Inspector(s)
Sarah Doepel (000858)
Bhavin Mistry (000863)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12-14, 18-20, 2024

The following intake(s) were inspected:

- Intake: #00114463 - related to alleged neglect of a resident by staff.
- Intake: #00114907 - complaint regarding a fracture sustained by a resident and alleged improper transfer by staff.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
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)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that the gate at the bottom of the stairway by the main entrance was kept closed and locked at all times.

Rationale and Summary
On June 12 and 19, 2024, the gate at the bottom of the stairway by the main entrance was left unlatched and unattended, allowing anyone to have access to the stairway.

Staff said the gate at the bottom of the stairway should have remained closed and locked at all times.

On June 19, 2024, staff fixed the gate, which allowed it to properly close. Following this, the gate closed on its own when the inspector went through it.

Failing to ensure the gate was closed and locked at all times, put the residents at risk, as they had access to the stairway.

Sources: observations of the gate and interviews with staff.

Date Remedy Implemented: June 19, 2024
[705769]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the

resident's health condition.

The licensee has failed to ensure that the Director was informed no later than one business day after an incident that caused injury to a resident for which the resident was taken to hospital and resulted in a significant change in health condition.

Rationale and Summary
A resident had an unwitnessed fall. The resident was assessed by the physician and x-rays were ordered to rule out a fracture secondary to a fall and the resident was sent to hospital due to a confirmed fracture.

The resident's mobility and transfer assessment was completed, citing a significant change in status as reason for assessment.

Staff acknowledged that a critical incident report was not submitted by the home.

By failing to inform the Director of the incident, the Director was unable to respond to the incident in a timely manner.

Sources: a resident's clinical records and interviews with staff.

[000858]