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

Public Report

Report Issue Date: December 17, 2024

Inspection Number: 2024-1410-0006

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19-22, 25-29, 2024 and December 3 and 4, 2024.

The following intake(s) were inspected:

- Intake: #00126059, related to prevention of abuse and neglect,
- Intake: #00130271, related to infection prevention and control program,
- Intake: #00131352, related to reporting and complaints.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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

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

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1. The licensee has failed to ensure that the standard issued by the Director with respect to IPAC was implemented.

Rationale and Summary

According to the IPAC Standard for LTCHs dated April 2022, revised September 2023, section 9.1 b), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program.

At minimum, routine practices shall include hand hygiene, including, but not limited to the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

On two different dates, three Personal Support Workers (PSWs) assisted different residents from the hallway to the dining room and did not perform hand hygiene between the residents as required.

The IPAC Lead stated that staff were to complete hand hygiene in between assisting residents and that they had observed the same on other units.

Staff not performing hand hygiene as required posed a risk for the spread of infection.

Sources: Observations and interview with the IPAC Lead.

2. The licensee has failed to ensure that the standard issued by the Director with respect to IPAC was implemented.

Rational and Summary

According to the IPAC Standard for LTCHs dated April 2022, revised September 2023, section 9.1, the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program.

At minimum, under section 9.1 (f) shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

A resident's room's door indicated contact precautions were in place. The contact precautions included the following: wear a mask, gloves and long-sleeved gown for direct care.

A PSW entered the resident's room to provide care without the required PPE. IPAC Lead stated that they should apply the appropriated PPE as required.

Staff not wearing the appropriate PPE as required posed a risk for the spread of

infection.

Sources: Observations and interview with RPN #106 and the IPAC Lead.
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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The licensee has failed to designate a staff member as the infection prevention and control lead who had education and experience in infection prevention and control practices.

The home designated, an Assistant Manager of Resident Care, to carry the duties of the IPAC Lead for the home. The AMRC stated that they did not have IPAC training as a Lead and had no background in IPAC. The Director of IPAC, Strategic Pandemic Recovery and Education, stated that the AMRC received general IPAC training by them and they had no IPAC background.

The licensee failed to ensure the IPAC lead had the education and experience in infection prevention and control practices.

Sources: Home's Outbreak documents, interviews with a AMAR and the Director of IPAC, Strategic Pandemic Recovery and Education.

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall ensure that:

1. Ensure all registered nurses receive in-person training on the monitoring and documenting of all signs and symptoms of infection. Training is to include guidelines

for reporting, documentation, and appropriate follow up. A supervised, knowledge test with a minimum pass score of 80% will be administered upon completion of the training.

2. A written record will be retained regarding the content of the material presented, the name and designation of the person who provided the training, the names of the participants and the dates of attendance. This record will be made available to the inspector immediately upon request.

Grounds
The licensee has failed to ensure that symptoms of infection for eight residents were monitored on every shift.

Rationale and Summary

The IPAC Lead stated that there were three nursing shifts in the home and when residents demonstrated signs and symptoms of infections they were to be monitored and documented on every shift.

Eight residents who exhibited signs and symptoms of infections were not monitored on every shifts.

Failure of the licensee to ensure residents exhibiting symptoms of infection are monitored every shift posed risk of harm to residents, specifically related to potential worsening of symptoms.

Sources: Review of the home's 'Line List', PHU declaration of outbreak, clinical health records for the residents, Critical Incident Report, and interviews with the IPAC-Lead.
This order must be complied with by January 24, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca