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
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Public Report

Report Issue Date: June 30, 2025

Inspection Number: 2025-1410-0003

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17-20, 23-27 and 30, 2025.

The following intakes were inspected related to prevention of abuse and neglect:
- Intake: #00143266
- Intake: #00145345
- Intake: #00146290
- Intake: #00148539

The following intake was inspected related to infection prevention and control:
- Intake: #00144702

The following intake was inspected related to unexpected death:
- Intake: #00143739

The following intakes were inspected related to improper care

- Intake: #00148392
- Intake: #00144561

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care related to transfers included clear directions to staff who provided care to the resident.

Sources: Progress note, care plan, mobility and transfer assessment, and interviews with Registered Practical Nurses (RPNs), the Assistant Manager of Resident Care (AMRC) and the Manager of Resident Care (MRC).

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the resident's transfer status changed.

Sources: Progress notes, resident mobility and transfer assessment, care plan, and interviews with an RPN, Physiotherapist, the AMRC, and the MRC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a nurse immediately reported an allegation of

staff to resident abuse.

Sources: A resident's clinical records, the home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that two staff used safe techniques when they assisted a resident during a transfer.

Sources: Critical incident report, the resident's care plan, progress notes, resident mobility transfer assessment, documentation survey report, Lifts Transfers and Repositioning policy, the home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident received weekly reassessments of their skin concerns. The resident's weekly wound assessment was incomplete as it did not include accurate information regarding the characteristics of the skin concern. Additionally, a weekly wound assessment was not completed for one week.

Sources: Progress notes and wound assessments, and interviews with the Registered Nurse (RN), home's Wound Care Lead, and the MRC.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was assessed by a registered dietician (RD) when they experienced deterioration of a skin concern.

Sources: Progress notes, dietary referrals and clinical alerts, and an interview with the MRC.