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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Public Report

Report Issue Date: September 18, 2025

Inspection Number: 2025-1410-0004

Inspection Type:
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): September 3-4, 9-12, 15-18, 2025

The following intake(s) were inspected:

- Intake: #00150123 - related to Skin & Wound Care
- Intake: #00151598 - related to Improper Care
- Intake: #00151458 - related to Falls Prevention
- Intake: #00151834 - related to Falls Prevention
- Intake: #00155814 - related to Falls Prevention
- Intake: #00154556 - related to Prevention of Abuse & Neglect
- Intake: #00157222 - related to Prevention of Abuse & Neglect

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

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

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

A staff member did not review a resident's care plan, and therefore did not implement the level of assistance required when indicated. As a result, the resident, who was found standing independently subsequently had a witnessed fall.

Sources: Critical incident report, the home's investigation notes, resident's care plan, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 staff used safe transferring techniques when assisting a resident.

A resident was not transferred in accordance to their transfer status, which resulted in a fall.

Sources: Interviews with staff, resident's clinical records, critical incident report, the home's internal investigation notes and lift/transfer policy

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a resident was assessed post-fall, and that the assessment was documented using a clinically appropriate assessment instrument.

A resident was not assessed by a registered team member prior to being moved post-fall. Additionally, a registered team member did not document the Scott falls

risk screening tool after becoming aware of the resident's fall, as per the home's policy.

Sources: Interviews with staff, resident's clinical records, critical incident report, and the home's falls policy

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The license has failed to comply with the home's skin and wound program when a resident did not receive a skin assessment upon return from the hospital.

Sources: Resident's clinical record, the home's skin and wound policy, and interview 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) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a skin and wound assessment was completed, when a resident was observed to have altered skin integrity. When the weekly skin and wound assessments were initiated, it was documented late and incomplete. There were missing components in the assessments as per the home's requirements.

Sources: Resident's clinical notes, interview with staff, critical incident investigation notes, home's skin and wound program policy

WRITTEN NOTIFICATION: Medication Management System

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies related to the home's medication management system were implemented. A resident had new orders prescribed, and it was checked and processed late. As per the home's pharmacy policies, new orders are to be verified by two registered staff as soon as possible. Lack of timely verification placed a resident at risk for receiving the incorrect treatment.

Sources: Pharmacy policies, interview with staff, and resident's clinical records.

WRITTEN NOTIFICATION: Administration of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that a resident received the drug that was ordered, instead received a discontinued drug, which resulted in discomfort to a resident.

Sources: Interviews with staff, resident's clinical records