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: October 31, 2025

Inspection Number: 2025-1410-0005

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 dates: October 21-24 and 27-31, 2025.

The following intakes were inspected related to a complaint:
-Intake: #00158521
-Intake: #00159034

The following intakes were inspected related to prevention of abuse and neglect:
-Intake: #00158415
-Intake: #00159107
-Intake: #00160581

The following intakes were inspected related to improper care:
-Intake: #00158556
-Intake: #00160246

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The following intake was inspected related to falls prevention and management:
-Intake: #00158810

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care for two residents were documented.

A) A resident required safety checks and care interventions at specific intervals.

Documentation did not accurately reflect the timing of care provided to the resident,

and records showed that staff had documented that they provided care, when the resident was absent from the unit.

Sources: Observations, resident's Point of Care (POC) documentation, interviews with the Assistant Manager of Resident Care (AMRC) and other staff.

B) When staff did not offer a resident a care intervention, they inaccurately documented that the resident had refused rather than documenting not applicable.

Sources: Resident's POC documentation, the home's internal investigation and interviews with the Manager of Resident Care (MRC).

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when the Registered Practical Nurse (RPN) had grounds to suspect that improper care to a resident had occurred, that the information was immediately reported to the Director.

Pursuant to section 154 (3), the licensee is vicariously liable for staff who have not complied with subsection 28 (1).

Sources: Critical Incident (CI) report, interviews with the RPN and the AMRC.

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 when the RPN and the AMRC had grounds to suspect that physical abuse to a resident occurred, that the information was immediately reported to the Director.

Sources: CI report, interviews with the RPN and the AMRC.

WRITTEN NOTIFICATION: End-of-Life Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 46
End-of-life care
s. 46. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs.

The licensee failed to ensure that a resident received end-of-life care in a manner

that met their needs.

A resident was not provided end-of-life nutrition care to meet their needs for a period of time.

Sources: resident's clinical records, Registered Team Member Communication to Dietary Aides, Nutrition Referral Tool (policy # FSM 10-08), the home's internal investigation, interviews with the MRC and other staff

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

A resident required safety checks and care interventions at specific intervals. During the inspection, the safety intervals were not conducted at the required frequency for the resident.

Sources: Observations, resident's POC documentation, interviews with the AMRC and other staff.

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) (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 when a resident exhibited altered skin integrity, that they received a complete skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Sources: CI reports, interviews with the MRC and other staff.