**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton Service Area Office**
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

**Amended Public Report (A1)**

**Report Issue Date** September 15, 2022
**Inspection Number** 2022_1704_0002
**Inspection Type**
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☒ Post-occupancy
☐ Other _____

**Licensee**
Westhills Care Centre Inc.

**Long-Term Care Home and City**
Westhills Care Centre, St. Catharines

**Lead Inspector**
Lisa Bos (683)

**Additional Inspector(s)**
Lesley Edwards (506)
Bernadette Susnik (120)
Sarah Lee (735818)
Kwesi Douglas (736409)

**Inspector Digital Signature**
Lisa Bos
Digitally signed by Lisa Bos
Date: 2022.09.15 15:04:47 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): August 17-19, 22-23 and 25-26, 2022.

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

- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Safe and Secure Home

## INSPECTION RESULTS

**During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.**

### WRITTEN NOTIFICATION: CONDITION OF A LICENCE

**NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton Service Area Office**
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

**Non-compliance with: FLTCA *s. 104 (4)***

The licensee has failed to comply with the conditions of its licence.

It is a condition of the licence that the licensee must comply with every agreement entered into under the FLTCA. [s.104 (3)].

The licensee's Development Agreement with the Ministry is an agreement entered into under the FLTCA that the licensee must comply with as a condition of its licence (O. Reg. 246/22, s. 319, s. 386). The Agreement required the development of 160 beds in accordance with the design standards/requirements of the Long-Term Care Home Design Manual, 2015 (along with other terms, conditions and documents).

As set out below, certain design standards/requirements of the Long-Term Care Home Design Manual, 2015, which were to be followed as per the Development Agreement, were not met. Accordingly, terms of the Development Agreement were not met. This resulted in the licensee not complying with the conditions of its licence.

**Rationale and Summary**
As per the Development Agreement, the licensee was required to design and build the long-term care (LTC) home in accordance with the Long-Term Care Home Design Manual, 2015 (Design Manual, 2015).

1. Section 8.1.4 of the Design Manual, 2015 sets out the following design standard/requirement:

   *8.1.4 When a device for the resident/staff communication and response system (nurse call system) is activated, it must be designed to clearly show where the signal is coming from, either inside the Resident Home Area (RHA) or in areas outside the RHA, so that staff can respond promptly.*

During the pre-occupancy review in April 2022, it was determined that the licensee did not ensure that the above requirement/standard was met before the due date provided.

Various areas of the home were identified to be missing a visual cue to clearly show staff the location of an active signal. The licensee identified that digital scrolling display panels (marquis) were to be installed and connected to the resident-staff communication and response system for this purpose. During the inspection, it was observed that a display panel was not installed in two resident dining rooms and the marquis panels installed in the other four dining rooms were not connected to the staff- communication and response system.

Further, s. 7.3.6 of the Long-Term Care Home Design Manual, 2015, was not complied with:

*7.3.6 Clean and soiled utility rooms must have a conveniently located hand washing sink for staff use.*

The sinks in each of the five soiled utility rooms were not dedicated hand wash sinks. The sinks were made of white plastic, deep and quite large with a long hose attached to the spigot, preventing staff from using it for handwashing purposes. The sinks in the soiled utility rooms on the third floor were used for manual device washing as per the Executive Director (ED) until mechanical washer/disinfectant machines could be installed in each of the two soiled utility rooms. The ED identified that the white sinks would be ideal for manual washing of personal hygiene items going forward and as a back up method should any washer/disinfectant machine fail, and that separate hand wash basins or sinks would be installed in the near future.

**Sources:** Staff interviews; observations and the Long-Term Care Home Design Manual, 2015.

[120]

## WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

**NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: FLTCA, 2021, s.184 (3)**

The licensee has failed to ensure that the home carried out the COVID-19 screening tool for Long-Term Care Homes and Retirement Homes as per section 9 of the Minister's Directive: COVID-19 response measures for long term care homes (LTCHs). LTCHs were required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long Term Care Homes was followed. LTCHs were required to follow this screening tool for minimum requirements and exemptions regarding active screening.

The COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units document required homes to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

The COVID-19 Screening Tool for Long-Term Care Homes directed at a minimum, that all individuals entering the home were actively screened using specific questions. This included reviewing each symptom (ten in total) and asking a set of six questions related to their possible exposure to COVID-19.

**Rationale and Summary**
Long-Term Care Home (LTCH) Inspectors were allowed into the home by a screener. The Inspectors were asked if they had any of the symptoms of COVID-19 and if they were instructed to self-isolate by a doctor, health care provider or public health unit; however, were not asked the specific questions as outlined in the screening tool. Inspectors were not asked if

they travelled or were in close contact with anyone who has travelled, if they were in close contact (or lived) with someone with COVID-19 symptoms or who tested positive for COVID-19 and if they tested positive on a rapid antigen test or a home-based self-testing kit, or whether they lived with someone who was waiting for COVID-19 test results. The Administrator confirmed they expected the screeners to review each required screening question with each visitor.

When individuals were not actively screened when entering the facility, all residents were placed at increased risk of transmission and possible exposure to COVID-19.

**Sources:** Observations of entrance screening; Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022; COVID-19 Screening Tool for Long Term Care Homes and Retirement Homes Version 12, effective June 27, 2022; COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, version 7 – June 27, 2022; Interview with Administrator and other staff.

[506]

## WRITTEN NOTIFICATION: PLAN OF CARE

**NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 *s. 29 (3) 7***

The licensee has failed to ensure that a resident's plan of care was based on interdisciplinary assessment of the type and level of assistance that was required related to bathing.

**Rationale and Summary**
A resident's written plan of care was reviewed 40 days after they were admitted to the home. There was a focus for the task of bathing but did not specify their bathing preference or level of assistance with bathing.

The Director of Nursing (DON) acknowledged that their care plan should have included direction for staff related to bathing.

**Sources:** A resident's clinical record; interview with the DON.

[683]

**NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 29 (4) (a)**

The licensee has failed to ensure that a Registered Dietitian (RD) who was a member of the staff of the home completed a nutritional assessment for a resident on admission.

**Rationale and Summary**

A resident's clinical record was reviewed 40 days after they were admitted to the home, and there was no documentation of a nutritional assessment completed on admission. The resident's written plan of care was drafted with sections for nutrition risk and hydration status, but specific details related to the resident were left blank.

The RD acknowledged that admission nutritional assessments were supposed to be completed within 14 days of a resident's admission but acknowledged that they were unable to complete the admission assessment on the resident. They reported that they spoke with the resident and updated their food preferences, but a full nutritional assessment had not been completed.

There was risk that nutrition and hydration risk factors may not have been identified when the admission nutrition assessment was not completed by the RD.

**Sources:** A resident's clinical record; interview with the RD and other staff.

[683]

## WRITTEN NOTIFICATION: HOUSEKEEPING

**NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 *s. 93 (2) (b) (i)***

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, procedures were developed and implemented for cleaning and disinfection of shower chairs using a low-level disinfectant in accordance with evidence-based practices.

**Rationale and Summary**

*Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013,* includes evidence-based practices specific to cleaning and disinfection of non-critical equipment which comes into contact with intact skin, i.e., shower chairs. It identifies to "dry equipment/devices after cleaning, before immersing in disinfectant, to prevent dilution of the disinfectant" and to "use the appropriate disinfectant for the task." Further it includes the need for procedures to identify how to clean gross soil from surfaces before disinfection using brushes or cloths and ensuring adherence to contact times listed on the manufacturer's label.

The licensee's policy and procedure for cleaning shower chairs did not include clear direction for cleaning and disinfecting shower chairs and that the above best practices were not taken into consideration. The procedure included direction to spray an approved disinfectant onto the chair surfaces, scrub all areas of the chair and let stand for five minutes. No other information was included about the type of disinfectant solution, how to apply it and other information included in the best practice document noted above to guide the staff. Further, no

information was included about how to clean and disinfect soft surfaces such as mesh backing that might be attached to a shower chair.

A shower chair was observed with a build-up of yellow and pink residues on the underside of the chair, including a build up of hair around the wheels. The mesh-based back rest was also discoloured in appearance.

A Personal Support Worker (PSW) reported using a disposable disinfectant wipe on the seat of a shower chair after first spraying any visible matter off with water. The seat was not dried before using the wipe. The remainder of the chair was not cleaned in between resident use and the PSW assumed that staff from the night shift deep cleaned the chair. The PSW also assumed that the mesh backing was laundered but did not know when it was last laundered or how often it should be laundered. Another PSW reported using a liquid disinfectant product to clean and disinfect shower chairs but was not aware of the name of the product and could not present it to the inspector when asked. The PSW stated that they applied it to certain surfaces using a cloth or towel and occasionally used a disinfectant wipe. The contact time for the wipes was one minute and 10 minutes for the liquid disinfectant.

According to the manufacturer of the disinfectant wipe, using it on a dry surface is recommended as that is how the product is tested for effectiveness. According to label instructions, the surface is to remain wet for one minute after application. It is therefore assumed that the surface of what is being disinfected would be dry and clean upon application in order for the disinfectant to be effective and remain undiluted.

The licensee did not ensure that their procedure was developed in accordance with evidence-based practices and subsequently implemented by staff.

**Sources:** Interviews; observation; review of procedure IC-03-06-08

[120]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 *s. 96 (2) (g)***

The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

**Rationale and Summary**

The hot water temperature for the showers in three home areas was measured. The water was allowed to run for approximately eight minutes and the water temperature ranged between 24.3°C and 37°C. A PSW reported that they encountered cold water at sinks and the showers and that they had to run the water for a long time. The lack of hot water created a situation

where the resident was not provided with a shower. Another PSW reported that the hot water had not been consistently hot over the last month. The maintenance person confirmed that they were aware of the issue and that several visits were made by technicians to determine the cause of the problem.

The hot water temperature log used by the staff to record their hot water temperatures did not include the temperature of any showers. Resident washroom hand sinks were most predominately measured. During a one-month period, there were six shifts with recordings below 40°C.

No policy or procedure was developed to ensure that the temperature of the hot water serving showers used by residents was maintained at a temperature of at least 40°C and what the follow-up action would entail.

**Sources:** Staff Interviews; water temperature logs; independent water temperature measurements.

[120]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

**NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

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

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

**Rationale and Summary**
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).

A PSW was observed to don PPE to provide care to a resident on droplet/contact precautions. The PSW was observed to don an N95 respirator over their surgical mask prior to the provision of care to the resident. They confirmed that they did not use the PPE properly.

Failure to comply with the IPAC Standard, to select and use PPE correctly, may have increased the risk of transmission of infections.

**Sources:** Observation of donning of a PSW; review of signage posted related to donning and doffing PPE and interviews with the PSW and other staff.

[506]

## WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

**NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 138 (1) (a) (ii)**

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

**Rationale and Summary**
The medication cart on a resident home area was observed to be unlocked. There were five residents in the nearby dining room and the RPN was not observed to be nearby. The RPN was unaware that the Inspector was able to open and close the medication cart drawers.

The RPN stated that they left to take a resident to their room and acknowledged that the medication cart should have been locked when it was unattended.

There was risk that residents may have accessed medications when the cart was left unlocked.

**Sources:** Observations on a resident home area; interview with an RPN.

[683]

## WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

**NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 140 (6)**

The licensee has failed to ensure that no resident administered a drug to themselves unless the administration was approved by the prescriber in consultation with the resident.

**Rationale and Summary**
A large bottle of a medication was observed on a resident's bed on three occasions. The resident stated that it was their medication and that they took it when they felt like they needed it, which was sometimes up to twice a day.

The DON stated that medications were not allowed at a resident's bedside unless there was an order for it. They acknowledged that the resident did not have an order for the medication at their bedside.

Failure to ensure that the resident was capable of self-administration may have placed the resident at risk of experiencing adverse effects.

**Sources:** Resident observations; a resident's clinical record; interview with the DON and other staff.

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton Service Area Office**
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

[683]