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

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

# Original Public Report

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| **Report Issue Date: February 2, 2024** | |
| **Inspection Number:** 2024-1704-0001 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** Westhills Care Centre Inc. | |
| **Long Term Care Home and City:** Westhills Care Centre, St Catharines | |
| **Lead Inspector**<br>Jennifer Allen (706480) | **Inspector Digital Signature**<br>Jennifer L Allen<br>Digitally signed by Jennifer L Allen<br>Date: 2024.02.08 11:37:49 -05'00' |
| **Additional Inspector(s)**<br>Klarizze Rozal (740765) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): **January 16, 18-19, 22-26, 29, 2024.**

The following intake(s) were inspected:

- Intake: #00101641 - CIS#3058-000031-23 - related to falls prevention and management.
- Intake: #00103955 - Complaint with concerns prevention of abuse and neglect.
- Intake: #00104177 - Complaint with concerns relating to resident care and support services.

- Intake: #00105951 - CIS#3058-000001-24 - related to Infection prevention and control.

The following intake was completed in this inspection:

- Intake: #00103639 - CIS#3058-000033-23 - related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# 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 (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 the plan set out for a resident with responsive behaviours, their intervention was followed.

**Rationale and Summary**

The plan of care for the resident's responsive behaviour, stated staff were to place a specific preventative intervention as per Behavioural Supports Ontario (BSO) recommendations for personal care.

It was observed that during the personal care for the resident, the specific preventative intervention was not used. During the care the resident displayed responsive behaviours towards the staff.
The staff member and a registered staff member stated they were aware that the resident had tendencies to display responsive behaviours towards staff during personal care.

**Sources**: Observations of the resident's care, the resident's health care records, interviews with staff and registered staff.
[706480]

## WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

According to O.Reg. 246/22 s. 2 (1) defines physical abuse under (c) as the use of physical force by a resident that causes physical injury to another resident.

**Rationale and Summary**

On a specified date, a resident had a physical altercation with another resident. A staff member witnessed the incident and acknowledged that the incident between the residents met the home's definition of physical abuse. The one resident sustained an injury.

Failure to protect the resident from physical abuse by another resident resulted in a physical injury.

**Sources:** Clinical records of both residents, Critical Incident Report, Resident Abuse & Neglect Policy, and interviews with staff.
[740765]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 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).

The home failed to ensure additional precautions, as part of the IPAC program, was followed by staff when entering a droplet precaution room and administering medication in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard).

**Rationale and Summary**
A registered staff member was observed to enter a room, under isolation precaution

with no personal protective equipment (PPE).
The registered staff member acknowledged that they did not apply PPE when entering.

The IPAC lead confirmed the observed room was on isolation precaution and PPE was required when entering and interacting with the resident.

Not properly selecting appropriate PPE increases the risk of transmission of infectious agents to nursing staff and other residents.

**Sources**: Observations of rooms on precaution and interviews with registered staff and the IPAC lead.
[706480]