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

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Original Public Report

Report Issue Date: October 2, 2024
Inspection Number: 2024-1704-0003
Inspection Type: Complaint Critical Incident
Licensee: Westhills Care Centre Inc.
Long Term Care Home and City: Westhills Care Centre, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29, 30, 2024 and September 3-6, 2024 and September 10, 2024

The following intake(s) were completed Critical Incident (CI) inspection:

- Intake: #00113766/CI: 3058-000011-24 was related to medication management
- Intake: #00120733/CI: 3058-000016-24 was related to a fall with injury

The following intake were completed in the complaint section:

- Intake: #00121164 was related to neglect, hydration and skin and wound care.

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

Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 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 their written policies and protocols for their medication management system were implemented in accordance with evidence-based practices.

In accordance with O. Reg 246/22, s. 11(1)(b) the licensee was required to ensure that the home's Narcotic Record-Individual Resident Policy was fully implemented and complied with. Specifically, to ensure the entries of narcotics were calculated and recorded when medications were removed for administration.

Rationale and Summary

On a date in April, one of a resident' narcotic medications were missing and unaccounted for. As per the home's investigation notes and acknowledged by the Director of Nursing (DON), that a registered staff counted the narcotics at the start of their shift but did not confirm and count the quantity before and after each medication administration during their shift.

Failure to ensure controlled substances were recorded and counted at the time the medication was removed for administration caused a discrepancy of narcotic count and posed a potential risk for resident harm and theft.

Sources: Critical Incident (CI), Narcotic Record-Individual Resident Policy, Narcotic Ward Drug Count, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 there is a written plan of care for a resident that sets out clear directions to staff who provide direct care.

Rationale and Summary
A resident's plan of care indicated that staff is to complete oral care for the resident using an intervention as they are not able to swallow fluids. There was no indication in the written plan of care that staff are to use the intervention for the resident.

During an interview, one staff member gave directions to other staff members to use an intervention. The Director of Nursing (DON) informed the inspector that staff were using that intervention. The DON confirmed that the intervention was not in the resident's written plan of care and that it was not clear for staff who provide direct care.

Failure to ensure the plan of care set out clear directions to staff who provide direct care posed a risk of staff being unaware of the requirements to provide care.

Sources: Resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in their plan.

Rationale and Summary
A resident had an injury. At the time, their plan of care included the resident to always have specific fall interventions.

A review of post-fall assessment, progress notes, and investigation notes it did not indicate that fall intervention was implemented. A staff acknowledged that the resident was not wearing the fall intervention at the time of the incident.

Failure to ensure that the resident's fall intervention was in place as specified in their plan, may have contributed to the injury.

Sources: Observations, a resident's clinical records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 the resident's plan of care was reviewed and revised when a resident's care needs changed.

Rationale and Summary
An assessment was completed for a resident's skin wound. The resident's plan of care was updated four days after with interventions for the wound.

A staff acknowledged that the plan of care should have been updated immediately with interventions for the resident's skin wound.

Failure to update the plan of care led to staff not being aware of interventions to alleviate the skin integrity for the resident.

Sources: Resident's Clinical Records 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) (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's skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
There was an order for a resident indicating a weekly skin assessment for multiple wounds. In review of the resident's skin and wound assessments, there was an assessment completed for all wounds on the appropriate dates in June. There was no skin assessment completed for the resident's injuries in July 2024.

The DON acknowledged that staff missed the weekly skin assessment for the resident.

Failure to complete a weekly skin assessment for the resident's skin integrity posed a risk of worsening skin integrity going unidentified.

Sources: Resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked

medication cart.

The licensee has failed to ensure controlled substances were stored in a separate locked area within a locked medication cart.

Rationale and Summary
In accordance with the home's Storage of Drugs Policy, all areas where medications were stored should be kept secured and locked at all times, specifically when not in use.

One of a resident's narcotic medications was identified as missing. At the end of the shift when completing the medication count, one of the narcotics in the medication card was unaccounted for.

A staff explained they did not confirm the count in the medication card before and after providing it to the resident. They acknowledged that controlled substances should be stored and locked when not in use and that they should not have taken the medication out of storage when they were not administering or counting the medications at that time, or provided them to the resident.

Failure to ensure controlled substances were stored in a separated locked area in a locked medication cart increased the risks for potential harm and theft.
Sources: Critical Incident, investigation notes, Storage of Drugs Policy, and interviews with the resident and staff.