

## 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

## **Public Report**

Report Issue Date: July 2, 2025

**Inspection Number**: 2025-1704-0003

**Inspection Type:**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): June 25, 30, and July 2, 2025.

The following intake(s) were inspected:

- Intake: #00144649 Critical Incident (CI) 3058-00009-25 Prevention of abuse and neglect.
- Intake: #00148595 CI 3058-000010-25 Falls prevention and management.

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

Prevention of Abuse and Neglect Falls Prevention and Management

## **INSPECTION RESULTS**



# 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

### **Non-Compliance Remedied**

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

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 a resident's plan of care set out clear directions to staff and others who provided direct care to the resident when their written care plan and progress notes indicated different directions for a specified intervention. The care plan direction for the intervention was remedied during the inspection on June 30, 2025.

**Sources**: Observation, resident's progress notes and care plan, interview with Director of Nursing (DON).

Date Remedy Implemented: June 30, 2025