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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Public Report

Report Issue Date: February 26, 2025
Inspection Number: 2025-1704-0001
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): February 20-21, 24-26, 2025.

The following intake(s) were inspected:

- Intake #00131879: CI (Critical Incident) #3058-000025-24 related to the prevention of abuse and neglect.
- Intake #00132053: CI #3058-000026-24 related to infection prevention and control (IPAC).
- Intake #00137556: CI #3058-000001-25 related to the prevention of abuse and neglect.
- Intake #00138988: CI #3058-000002-25 related to IPAC.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

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

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, "physical abuse” means, the use of physical force by anyone other than a resident that causes physical injury or pain, or the use of physical force by a resident that causes physical injury to another resident.

A resident hit another resident and the resident sustained an injury as a result.

Sources: CI report, residents progress notes, photo of a resident, and interview with the Director of Nursing (DON).

B) The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.

A resident was upset after having sustained a physical injury when staff used excessive force while providing care.

Sources: Video footage, a resident's clinical record, the home's investigation notes,

CI report, interview with the DON.

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) 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 an allegation of abuse to a resident was reported immediately to the Director when a staff member was made aware of the allegation on a specified date and it was not reported to the Director until the following day.

Sources: CI report, the home's investigation notes.

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 licensee has failed to comply with additional requirement 4.3 of the IPAC Standard for Long-Term Care Homes, revised September 2023, when the outbreak management team (OMT) and interdisciplinary IPAC team did not conduct a debrief session following the resolution of an outbreak on a specified date or create a summary of recommendations for improvements to outbreak management practices.

Sources: E-mail from the DON, interview with the DON and interim IPAC lead.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (a)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

The licensee has failed to comply with the home's policy to promote zero tolerance. A charge nurse was made aware of alleged abuse to a resident on a specified date and did not assess and examine the resident, initiate an investigation and document the findings on the resident's progress notes.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the home's policy to promote zero tolerance contains procedures and interventions to assist and support residents who have been allegedly abused or neglected.

Specifically, the home's policy to promote zero tolerance indicated that upon being notified of any alleged abuse, the charge nurse must assess and examine the resident, initiate an investigation and document the findings on the resident's progress notes. This requirement was not completed.

Sources: A resident's clinical record, the home's policy, the home's investigation notes.