

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: September 26, 2025
Inspection Number: 2025-1704-0004
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): September 22-26, 2025

The following intake(s) were inspected:

- Intake: #00153403 - Critical Incident (CI) #3058-000012-25 - Resident care and support services
- Intake: #00153447 -CI #3058-000013-25 - Fall prevention and management
- Intake: #00154706- Complaint regarding prevention of abuse and neglect

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

- Resident Care and Support Services
- Prevention of Abuse and Neglect
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero

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tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of resident's was complied with. The licensee failed to ensure that a staff member was immediately suspended pending investigation when an allegation of abuse was reported.

Sources: Home's policy titled "Resident Abuse and Neglect Policy", last revised April 2024, home's investigation notes, interviews with management.

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 incident of alleged abuse to a resident by staff, which resulted in harm or risk of harm to a resident was reported immediately to the Director on a specified date in July. This incident was reported fourteen (14) days later.

Sources: Resident's clinical records, investigation notes completed by the home, Critical Incident #3058-000014-25

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

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(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident who required incontinence care products to remain clean and dry received this, a resident did not receive sufficient changes on a specified date in July, to promote this.

Sources: Resident's clinical records, home's investigation notes, interview with management.

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that resident's Substitute Decision Maker (SDM) was immediately notified when allegations of alleged abuse were made regarding staff to resident abuse on a specified date in July. The SDM was made aware sixteen (16) days after the allegation was made.

Sources: Resident's clinical records, Interview with management.