Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: December 29, 2023	
Inspection Number: 2023-1704-0005	
Inspection Type: Critical Incident	
Licensee: Westhills Care Centre Inc.	
Long Term Care Home and City: Westhills Care Centre, St Catharines	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 20-22 and 27, 2023.

The following intakes were inspected:

- Intake #00004849 Critical Incident Report (CIR) related to prevention of abuse and neglect.
- Intake #00098017 CIR related to infection prevention and control program.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

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 (10) (b)
Plan of care
When reassessment, revision is required
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.

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary

On a specified date during the inspection, Inspector #741074 noted that a resident who was included on the list of residents on Additional Precautions provided by the Infection Prevention and Control (IPAC) Lead, did not have point-of-care signage at their room's door indicating enhanced IPAC measures were in place.

The IPAC Lead indicated that this was due to the unique care needs of the resident.

Later during the inspection, Inspector #741074 noted that the same resident had point-of-care signage at their room's door indicating enhanced IPAC measures were in place. The IPAC Lead indicated that after they had spoken with the inspector they spoke to the nurse on the floor and updated the resident's care plan and kardex to include the specified care needs of the resident, the Additional Precautions in place, and follow-up actions required.

Sources: Observations, list of residents on Additional Precautions, interviews with staff, and resident's care plan and kardex.

Date Remedy Implemented: December 27, 2022 [741074].

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 failed to implement the Infection Prevention and Control (IPAC) Standard for Long-term Care Homes (April 2022). Specifically, the licensee failed to ensure that Additional Precautions included point-of-care signage indicating that enhanced IPAC control measures were in place.

Rationale and Summary

During the course of the inspection, Inspector #741074 observed that six residents on a specified resident home area had yellow hammocks and isolation carts with

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personal protective equipment outside of their rooms but did not have point-of-care signage indicating that enhanced IPAC control measures were in place.

The IPAC Lead indicated that these six residents required signage indicating that enhanced IPAC control measures were in place.

All residents had point-of-care signage indicating that enhanced IPAC control measures were in place by end of day December 27, 2023.

Sources: Observations, list of residents on Additional Precautions, and interview with IPAC Lead.

Date Remedy Implemented: December 27, 2023 [741074].

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 failed to ensure that two residents were protected from physical abuse on a specified date.

Section 2 (1) (c) of the Ontario Regulation 246/22 defines physical abuse as: the use of physical force by a resident that causes physical injury to another resident (“mauvais traitements d’ordre physique”).

Rationale and Summary

On a specified date, two residents engaged in an unwitnessed physical altercation with each other. Staff overheard the incident and assessed the residents immediately. Both residents sustained physical injuries.

Failure to protect these residents from physical abuse caused actual harm to them when they sustained physical injuries.

Sources: Critical Incident Report, resident progress notes, risk management incident reports, and interviews with staff [741074].

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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 failed to implement the Infection Prevention and Control Standard (April 2022). Specifically, the licensee failed to ensure that Additional Precautions included the appropriate selection, application, and removal of personal protective equipment (PPE).

Rationale and Summary

During the course of the inspection, Inspector #741074 observed a staff person incorrectly select, apply, and remove their PPE when assisting a resident in their room who was on additional precautions. On the same day, Inspector #741074 observed another staff person incorrectly remove their PPE after leaving a resident's room who was on additional precautions.

Later during the inspection, Inspector #741074 observed one of the same staff persons incorrectly select their PPE when providing care to a resident on additional precautions.

Failure to appropriately select, apply, and remove PPE when providing care to residents on additional precautions may have increased the transmission risk of infectious agents.

Sources: Observations, point-of-care signage, COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings, and interview with staff [741074].