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

Hamilton Service Area Office
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Amended Public Report (A1)

Report Issue Date September 15, 2022
Inspection Number 2022-1704-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Westhills Care Centre Inc.

Long-Term Care Home and City
Westhills Care Centre, St. Catharines

Lead Inspector
Angela Finlay (705243)

Inspector Digital Signature
Angela Finlay Digitally signed by Angela Finlay Date: 2022.09.15 09:46:00 -04'00'

Inspector #740882 (Jonathan Conti) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 21-22, 25-27, and August 2-5, and 8, 2022.

The following intake(s) were inspected:

- Intake #012202-22 (CIS #3058-000001-22) related to an unexpected death.
- Intake #012210-22 (Complaint) related to admissions.
- Intake #014271-22 and 014817-22 (Complaint) related to nutrition, falls prevention, medication management, housekeeping and laundry and personal care.

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services

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

O. Reg. 246/22, s. 102 (2) b

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

As per the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, the homes hand hygiene program shall include support for residents to perform hand hygiene prior to receiving meals and snacks.

On July 21, 2022, the inspector observed 23 residents in one home area who were independently feeding themselves one of the two handheld lunch options. The residents were not assisted with hand hygiene. The Certainty wipes container that staff were to use to support residents with their hand hygiene was empty.

On July 22, 2022, the inspector observed staff walking around with a portable hand sanitizer pump and assisting residents. The Certainty wipes container that was empty had been refilled.

Sources: Observations; IPAC Standard, dated April 2022; and interview with staff.

Date Remedy Implemented: July 22, 2022 [705243]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home was carried out.

The COVID-19 guidance document for long-term care homes in Ontario, stated that homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

The home completed this electronically by adding a COVID-19 symptom monitoring order into each resident's physician orders. The order required for supplementary documentation to be added that would prompt staff to record the residents' temperatures. The registered staff would then be prompted to complete this order once daily through the electronic administration record.

On July 22, 2022, the inspector completed an audit of five residents, one from each resident home area. Of the five residents reviewed, one resident did not have the supplementary documentation of temperature added to their COVID-19 symptom monitoring order and thus there was no record of their temperature being monitored daily and one resident did not have the COVID-19 symptom monitoring order in their orders at all.

On July 26, 2022, the inspector was informed that the home completed an audit of all of the residents of the home and the proper COVID-19 symptom monitoring order with the included supplementary documentation of temperature was on every resident's orders. The inspector reviewed the two previously identified residents and their COVID-19 symptom monitoring orders had been updated appropriately.

Sources: Resident #005, #006, #007, #008 and #009 clinical records; The COVID-19 guidance document for long-term care homes in Ontario, last changed on June 11, 2022; and interviews with staff.

Date Remedy Implemented: July 26, 2022 [705243]

NC#03 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 3 (11)

The licensee has failed to ensure that resident #004 lived in a safe and clean environment.

On August 4, 2022, the inspectors observed soiled washcloths and dirty gloves with markings indicating bodily fluids on the floor in resident #004's bathroom.

The home's laundry policies stated that soiled linen must be bagged and to follow infection prevention and public health guidelines. Public Health Ontario's (PHO) document titled, "Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings" stated to bag or otherwise contain soiled laundry at the point-of-care.

A Personal Support Worker (PSW) stated the washcloths and gloves should not have been left in the bathroom and they should have been removed immediately. The Administrator stated it is the home's policy that staff place soiled linens into the carts outside of the resident's room immediately after providing care and that this should not have happened.

A PSW removed the soiled washcloths and gloves from the bathroom immediately and the home posted a sign at the nursing station reminding staff to remove soiled and dirty supplies from resident's rooms immediately after providing care.

Sources: Observations; the Home's Laundry Policies titled, "Laundry Policy: SUBJECT: Laundry Program Outline", Policy No. ES-05-01-01, Date of Origin: March 2021, "Laundry Policy: SUBJECT: Transportation of Linen", Policy No. ES-05-01-02, Date of Origin: March 2021, and "Laundry Policy: SUBJECT: Identification of Soiled Linen", Policy No. ES-05-01-08, Date of Origin: March 2021; Public Health Ontario documented titled, "Best Practices for Environmental

Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition" April 2018; and interviews with PSW #116 and Administrator #100.

Date Remedy Implemented: August 4, 2022 [705243]

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for resident #004 and resident #003 was provided as specified in the plan.

Rationale and Summary

A) Resident #004's plan of care stated that they were a high risk for falls and that they were to have a specific falls intervention in place at all times.

There were six different dates that it was documented that the specific falls intervention was not in place as it was not available.

Interviews with different staff members indicated the home did have a process in place to ensure this falls intervention was always available and, in these instances, staff were not following the process.

Not providing the intervention to the resident as specified in the plan of care placed the resident at risk of injury if they were to fall.

Sources: Resident #004's clinical records; and interviews with PSW #117, RN #118 and the Administrator. [705243]

B) Resident #003's plan of care stated that staff were to ensure the call bell was within the resident's reach. The resident was a high risk for falls and required extensive assistance for locomotion.

On August 5, 2022, inspectors were approached by a family member who was requiring assistance of staff and very upset that resident #003 could not access their call bell. The resident was observed in their bedroom with the call bell out of reach. The resident was not able to request assistance and thus there was a potential risk to the resident's health and safety.

Sources: Resident #003's clinical records; observations; and interviews with the SDM and staff. [705243]

WRITTEN NOTIFICATION: ORAL CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

The licensee has failed to ensure that resident #004 received mouth care in the morning and the evening.

Rationale and Summary
Resident #004 required total assistance for personal hygiene.

On August 4, 2022, inspectors moved the resident's toothbrush from where it was placed in a dish to the ledge of the countertop. The toothbrush was also observed to have a small amount of dried toothpaste on the bristles. On August 5, 2022, inspectors observed that the resident's toothbrush had not moved from where it was placed the day before and that the same amount of dried toothpaste remained in the same spot on the bristles of the toothbrush indicating it had not been used or touched for evening care on August 4 or morning care on August 5, 2022.

A PSW stated that staff only assisted the resident with mouthwash the morning of August 5, 2022, and did not brush the resident's teeth as staff were too busy. The Administrator stated it was the expectation that staff would brush the residents teeth for morning and evening care and that mouthwash could be used in addition to brushing a resident's teeth but not as a replacement.

As per the documentation that PSWs were to complete regarding personal hygiene, there were two other incidents noted on July 29 and 30, 2022, where only the evening provision of personal hygiene was documented to be completed.

Staff not providing oral care twice per day placed the resident at risk for poor personal hygiene.

Sources: Resident #004's clinical records; Observations; and Interviews with PSW #113 and the Administrator. [705243]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that written policies and protocols were implemented for the medication management system to ensure the accurate acquisition, dispensing, receipt, and administration of all drugs used in the home.

Rationale and Summary

The Home's policy for their medication management system instructed staff to refer to the Manual for MediSystem Serviced Homes for the relevant information to the acquisition, prescribing, dispensing, receipt, storage, administration and destruction and disposal of medications within the Home. The manual stated that the pharmacist would report any problems with a medication order to the nurse or prescriber immediately and that a Pharmacy Intervention Form would be sent with the order as a further clarification of the problem. The delivery was to be accompanied by a packing slip itemizing all of the items contained in the delivery and this was then to be inserted into the Drug Record Book. The Drug Record Book was to include the date the drug was ordered as well as the date the drug was received and that any discrepancies were to be reported to the pharmacy immediately.

Resident #003 had physician orders for two specific prescriptions.

The resident did not receive one of the prescriptions as ordered on August 1 and 2, 2022. They also did not receive their other prescription as ordered on July 28, 29, 30 and August 2, 3, 4, and 5, 2022.

Both of the prescriptions were re-ordered by the home on August 2, 2022. The pharmacy delivered one of the prescriptions but not the other.

The Administrator stated the pharmacy did not report any problems with the second prescription order to the home and did not send a Pharmacy Intervention Form to the home as expected. RPN #121 stated that the discrepancy was identified as staff continued to document "drug not available" in the resident's medication administration record but that pharmacy had yet to be followed-up with.

By not implementing the medication management system the resident was placed at risk of not receiving physician ordered prescriptions as intended.

Sources: Resident #003's clinical records; the home's Drug Record Book; the home's policy titled, "SUBJECT: Medication Management System" Policy No RC-07-01-02, Date of Origin: January 2021; Manual for MediSystem Serviced Homes, Updated June 2022; and interviews with RPN #121, RN #106 and the Administrator. [705243]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when resident #004 had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

Resident #004 had a fall. The home completed a Morse Falls Risk Scale, a Risk Management report, and a falls progress note. There was no clinically appropriate post-fall assessment completed.

The Registered Nurses Association of Ontario's clinical best practice guidelines document titled, "Preventing Falls and Reducing Injury from Falls Fourth Edition" stated that a post-fall assessment should be used to determine the factors that contributed to a fall and to inform of strategies to prevent future falls.

The home's falls policy instructed registered staff to conduct a head-to-toe assessment, initiate a head injury routine (HIR) if applicable, complete a Risk Management report and to document a falls progress note and post fall huddle.

The Risk Management report that staff were to complete was not specifically designed for falls. The Morse Falls Risk Scale was a validated assessment tool to assess a resident's risk of falling but was not an assessment of a specific fall and did not identify contributing factors to a specific fall or strategies to prevent future falls. The falls progress note and post fall huddle were not clinically appropriate assessment instruments as they also did not identify contributing factors of the fall or strategies to prevent future falls.

At the end of the inspection, the Administrator and Staff Educator had created a draft of a clinically appropriate post-fall assessment instrument and draft revisions to the homes falls policy to reflect the use of a new post-fall assessment instrument with plans to implement and train staff on this new assessment.

Not completing a clinically appropriate post-fall assessment after a resident has fallen, places the residents at risk for future falls and injuries.

Sources: Resident #004's clinical records; the Home's falls policy titled, "Subject: Fall Prevention & Management Program" Policy No ND-F-03-01, Last review/Update: April 2022; Revised Morse Fall Risk Scale; and interviews with RN #118, RN #106, and the Administrator and Staff Educator. [705243]

WRITTEN NOTIFICATION: LICENSEE CONSIDERATION AND APPROVAL

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 51 (7)

The licensee has failed to ensure to review the assessments and information provided to the home for resident #002 and approve their admission to the home.

Rationale and Summary

Resident #002 had behaviour assessments completed in March of 2022.

The home sent a written notice of withholding admission in June of 2022. The reason for withholding admission was stated that the facility was unable to accommodate due to a lack of nursing expertise related to skill set.

The home was unable to provide evidence as to what nursing expertise the home lacked that resident #002 would have required. The Administrator acknowledged that the resident should not have been rejected based on this assessment and that staff may have requested further assessments prior to rejecting the resident but was unable to provide any evidence that any other actions or follow-up was taken in relation to this resident's application.

Sources: Resident #002's Behaviour Assessments; Westhills Written Notice of Withholding Admission; and interview with the Administrator. [705243]

WRITTEN NOTIFICATION: WRITTEN NOTICE IF LICENSEE WITHHOLDS APPROVAL

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 51 (9) (b)

The licensee has failed to ensure a written notice was provided to the appropriate placement co-ordinator that included a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care for withholding admission to resident #002.

Rationale and Summary

The home sent the appropriate placement co-ordinator a written notice of withholding admission to resident #002 in June of 2022. The reason stated for withholding admission was that the facility was unable to accommodate due to a lack of nursing expertise related to skill set and staff to manage the severity of the resident's behaviours. No explanation as to what specific nursing expertise the home lacked or what the resident's behaviours that the home was unable to manage were included in the letter.

The Administrator stated that Home and Community Care Support Services informed the home that they needed to provide more detailed explanations in their rejection letters.

Sources: Westhills Written Notice of Withholding Admission; and interview with the Administrator. [705243]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2

The licensee has failed to ensure that the Director was immediately informed of the unexpected death of resident #001.

Rationale and Summary
Resident #001 passed away unexpectedly. The licensee did not immediately contact the afterhours line to report the incident to the Director and submitted a critical incident report the next day.

In an interview with the Administrator and Director of Nursing, they acknowledged that the afterhours line should have been called immediately to report this.

Sources: Resident #001's clinical records; Critical Incident Report #3058-000001-22; and an interview with the administrator and director of nursing. [705243]

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi

The licensee has failed to ensure that the emergency plan for medical emergencies was complied with.

Rationale and Summary
In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the home had an emergency plan for medical emergencies and that this plan was complied with.

Specifically, staff did not comply with the policy titled, "Medical Emergency CODE "BLUE/STAT RN"", dated May 2021, which was captured in the licensee's emergency plans.

The home's emergency plan instructed staff to announce, "STAT RN" and the location of the emergency over the public address (PA) system three times and to proceed with cardiopulmonary resuscitation (CPR) if a resident became unconscious.

A resident was found in a medical emergency by an RPN. Another RPN, an RN, and the resident's doctor who was on-site at the time of the incident attended to the scene. The staff did not call a "STAT RN" code over the PA system and they did not perform CPR.

The resident had a valid do not resuscitate (DNR) order in place and the resident's SDM had signed a document titled, "Westhills Advanced Health Care Wishes" stating that no CPR was

to be provided to the resident. The doctors' notes of the incident also made mention of the residents DNR order.

The RPN stated that they did not announce a "STAT RN" code as this could only be done through the PA system at the nursing desk and would have required them to leave the resident unattended. Two of the staff who attended to the emergency stated that they did not perform CPR on the resident as the resident had a DNR order in place.

The Administrator and Director of Nursing stated that the home's emergency plan would need to be updated to reflect options for staff to call a STAT RN without leaving a resident's side and instructions for staff to refer to a resident's code status prior to performing CPR.

Sources: Resident #001's clinical records; the home's emergency plan titled, **"**Medical Emergency CODE "BLUE/STAT RN", Policy No. FDM-08-12-01, Date of Origin: May 2021; Document titled, "Westhills Advanced Health Care Wishes"; and interviews with staff. [705243]