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

North District
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Original Public Report

Report Issue Date: December 7, 2023
Inspection Number: 2023-1129-0003
Inspection Type: Complaint Critical Incident
Licensee: Wiigwas Elder and Senior Care
Long Term Care Home and City: Wiigwas Elder and Senior Care, Kenora

Lead Inspector	**Inspector Digital Signature**
Samantha Fabiilli (000701)	Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2023.12.18 14:45:44 -05'00'

Additional Inspector(s)
Jessamyn Spidel (000697)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-19, 2023
The inspection occurred offsite on the following date(s): October 23-27, 2023

The following intake(s) were inspected:
- Two intakes related to falls.
- One intake related to safe and secure home/IPAC.
- One intake related to environmental hazard.
- One intake related to improper/incompetent care.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that care set out in the plan of care was provided to a resident.

1.
Rationale and Summary
A resident was observed multiple times without the use of an intervention, that was specified for use in their care plan.

A review of documentation for this resident indicated that they were still utilizing this intervention.

An interview with a staff member indicated that they had only seen this resident using the this specified intervention once in an approximate two week period; another staff member confirmed that this resident had not been using the specified intervention.

An interview with Director of Care (DOC) confirmed that the expectation for staff is to implement care which is set out in a resident's care plan.

Sources: Observations of a resident; Review of a resident's documentation records; Review of a resident's care plan; and Interviews with staff and DOC. [000697]

2.
Rationale and Summary:
A resident's plan of care indicated that an intervention was to be in place. The DOC confirmed that the intervention was identified in the resident's care plan.

During observations, the intervention was not noted to be in place.

Staff members indicated that the specific intervention was not used for the resident.

The DOC confirmed that if an intervention was identified in the resident's care plan, it was their expectation it would be utilized.

Not utilizing the intervention posed a moderate risk to the resident.

Sources: Observations; A resident's care plan; A resident's progress notes and

assessments; Interviews with staff and DOC.
[000701]

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
Staff and others to be kept aware
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary
A resident's care plan specified interventions related to a specific aspect of a resident's care.

Interviews with staff assigned to provide direct care for the resident, indicated that they were not aware of the interventions listed in the resident's care plan.

An interview with the DOC confirmed that all staff providing direct care to a resident should be aware of the contents in their care plan.

Sources: Observations of a resident; A resident's care plan; Review of a resident's documented care; and Interviews with staff and DOC. [000697]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that an alleged incident towards a resident, that the home was aware of, was immediately investigated.

Rationale and Summary:
A staff member witnessed an incident involving a resident and another staff member. Progress notes also indicated that staff informed the previous DOC of this incident.

The previous DOC indicated that they were made aware of this alleged incident by reading it in a progress note and that it was not reported to them by anyone. The previous DOC also indicated that once they became aware of this incident, they did not initiate an investigation.

Not immediately investigating this incident posed a moderate risk to the resident.

Sources: A resident's progress notes; Interviews with staff and previous DOC. [000701]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident had occurred immediately reported it to the Director.

Rationale and Summary
A Critical Incident (CI) was submitted regarding an incident involving resident care.

A review of the home's records surrounding the incident confirmed that the home investigated the incident for potential improper or incompetent care.

An interview with the previous DOC, confirmed that this incident was not reported to the Director immediately and should have been.

Sources: A review of a Critical Incident; Home's internal investigation file; A resident's progress notes; A policy of the home; and interview with previous DOC. [000697]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
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 a suspected incident towards a resident, which resulted in risk of harm to a resident, was immediately reported to the Director.

Rationale and Summary:
A progress note indicated that staff witnessed an incident towards a resident.

The previous DOC indicated that they were made aware of this alleged incident by reading it in a progress note, however, this incident was not reported to the Director.

Not immediately reporting this incident to the Director resulted in a low risk and low impact to the resident.

Sources: A resident's progress notes; an Interview with the previous DOC. [000701]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was assessed by the home's registered dietitian.

Rationale and Summary
A resident with altered skin integrity was not referred to the home's Registered Dietitian (RD).

Assessments for the resident identified an extended period of time without a documented RD referral or assessment.

A staff member confirmed that a RD referral should have been made for a resident.
A staff member confirmed that a referral had not been made.

Sources: A Critical Incident (CI) report; Home's investigation records; A resident's progress notes; Dietary Assessments; Review of a resident's order's record; A policy of the home; and Interviews with staff, previous DOC, and Nutritional Manager. [000697]

WRITTEN NOTIFICATION: Registered dietitian

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)
Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home, had been onsite at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary
A review of records and an interview with Nutritional Manager confirmed that an RD employed by the home had been working remotely, and was only available onsite in the home for one day each month.

Interviews with the Administrator, and previous DOC, confirmed that the home did not have an RD working onsite in the home for the minimum number of required hours based on the number of residents in the home.

Sources: Dietary Assessments for a resident; A resident's order record; A home's policy; and Interviews with staff, Administrator, previous DOC, and Nutritional Manager. [000697]