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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1129-0001
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**
Eva Namysl (000696)	Eva Namysl Digitally signed by Eva Namysl Date: 2024.04.08 10:20:51 -04'00'

Additional Inspector(s)
Jessamyn Spidel (000697)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18 - 21, 2024.

The following intake(s) were inspected:

- A complaint related to concerns re: management of responsive behaviours.
- An intake related to alleged Improper/incompetent care of a resident resulting in injury.
- An intake related to a change in a resident's health condition.
- A complaint related to concerns re: alleged neglect and palliative care of resident.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker had been given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
The Director received a complaint alleging that the Substitute Decision Maker (SDM) of a resident had not been made aware of a change in the resident's condition.

A review of the resident's progress notes indicated that the staff identified changes in the resident's condition but had not notified the SDM until a later date.

Interviews with the Director of Care (DOC) confirmed that the resident's SDM should have been made aware of a change in the resident's condition immediately.

There was minimal risk and impact identified to the resident as a result of resident's SDM not being made aware of the resident's change in condition.

Sources: Review of resident's progress notes; Review of a complaint received to the Director; and Interviews with the DOC and other staff. [000697]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1. The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
The Director received a complaint from resident's SDM indicating that staff did not provide care as required during a change in resident's condition.

The resident's care plan required staff to reposition the resident.

A review of documentation of care confirmed gaps in documentation and inconsistencies in the level of assistance the resident required during a period of time.

An interview with the DOC confirmed that gaps and inconsistencies in the level of care required which were identified in documentation, had not meet the home's expectations.

There was minimal risk and impact identified to the resident as a result of missing or inconsistent documentation.

Sources: Review of resident's care plan, progress notes, and documentation of care; Complaint received; and interviews with the DOC, Quality and Risk Management Lead, and other staff. [000697]

2. The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
A review of a resident's care plan confirmed that staff were required to monitor and document the resident's health condition as per the administration records.

The administration record for the resident, identified gaps when the health condition was not documented as required.

An interview with the DOC confirmed the gaps in documentation identified in the administration record.

There was minimal risk identified to the resident as a result of staff failing to document the resident's health condition.

Sources: A review of resident's care plan, administration records; After Hours (AH) report and Critical Incident report; and interviews with the DOC and staff. [000697]