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
Telephone: (800) 663-6965

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 18, 2024
Original Report Issue Date: October 16, 2024
Inspection Number: 2024-1129-0003 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Wiigwas Elder and Senior Care
Long Term Care Home and City: Wiigwas Elder and Senior Care, Kenora

AMENDED INSPECTION SUMMARY

This report has been amended to:
Remove a Written Notification related to O. Reg 246/22 s. 105 which had been included in error.

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
Telephone: (800) 663-6965

Amended Public Report (A1)

Amended Report Issue Date: October 18, 2024

Original Report Issue Date: October 16, 2024

Inspection Number: 2024-1129-0003 (A1)

Inspection Type:
Complaint
Critical Incident

Licensee: Wiigwas Elder and Senior Care

Long Term Care Home and City: Wiigwas Elder and Senior Care, Kenora

AMENDED INSPECTION SUMMARY

This report has been amended to:
Remove a Written Notification related to O. Reg 246/22 s. 105 which had been included in error.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 17-19, 2024

The following intake(s) were inspected:

- An intake related to alleged physical abuse of a resident by a resident.
- An intake related to alleged neglect of a resident by staff.
- An intake related to alleged verbal and physical abuse of a resident by a resident.
- A complaint with concerns regarding alleged abuse and neglect of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 a resident was not neglected by staff.

O. Reg 246/22 s. 7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
The home's internal investigation file for a Critical Incident (CI) confirmed staff had

not responded to a resident's care needs in a timely manner.

An interview with the home's Administrator confirmed that care should have been provided within an appropriate amount of time.

Sources: Review of CI #2620-000008-24; Review of the home's internal investigation into CI #2620-000008-24; Review of home policies under the Zero Tolerance of Abuse and Neglect program; and Interviews with staff and the home's Administrator.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 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 tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee had failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
During an interview with a Personal Support Worker (PSW), allegations of suspected abuse and neglect of residents had been identified.

The home's policy to promote zero tolerance of abuse and neglect requires staff to report any witnessed or suspected abuse and neglect of residents to management

in the home immediately.

The Director of Nursing Care (DOC) and Administrator in the home both stated that they had not been made aware of any of the allegations of suspected abuse and neglect identified, and that if they had been made aware they would have taken immediate action.

Sources: Review of a Communication Notebook; review of a letter addressed to the home's management by staff; review of home policy titled Zero Tolerance of Resident Abuse and Neglect; and Interviews with the home's Administrator, DOC and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 had failed to immediately report the suspicion of abuse and neglect to residents by anyone or by the licensee or staff that resulted in harm to the resident, and the information upon which it is based to the Director.

A.
Rationale and Summary

A report was received by the Director one day after an incident of suspected abuse or neglect had been identified to a resident by staff.

An interview with the home's Administrator confirmed an immediate report should have been made to the Director.

Sources: Review of CI report #2620-000008-24; and an Interview with the home's Administrator.

B.
Rationale and Summary

A resident altercation occurred and the home did not immediately report the incident to the Director as required.

In an interview with the Administrator they indicated that the expectation for staff was to immediately inform the Director when an incident of resident abuse occurs within the home.

Sources: Residents progress notes; CI Report #2620-000006-24; and an Interview with the Administrator.

WRITTEN NOTIFICATION: When PASD may be used

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD

described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee had failed to ensure that a Personal Assistive Safety Device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD had been included in the resident's plan of care.

Rationale and Summary
Observations were made of a resident with a PASD in use.

An interview with a Registered Practical Nurse (RPN) and the DOC) confirmed that they could not locate an order or consent for the resident to use the PASD.

Sources: Observations of a resident; Review of a resident's medical chart and current care plan; and Interviews with the home's Administrator, DOC, and staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(a) any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance; and
(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 had failed to ensure that any standard or protocol issued by the

Director with respect to infection prevention and control has been implemented. Specifically residents had not been supported to perform hand hygiene prior to receiving a meal.

Rationale and Summary
Observations identified hand hygiene was offered inconsistently to residents.

An interview with the home's Administrator confirmed that hand hygiene should be offered to all resident's before their meals.

Sources: Observations; and an Interview with the home's Administrator.

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)
Hiring staff, accepting volunteers
s. 252 (2) The police record check must be,
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee failed to ensure that an employee had completed a vulnerable sector police record check within six months before they were hired by the home.

Rationale and Summary
A review of an employee's file had identified that their vulnerable sector police record check was completed more than six months prior to being hired by the home.

An interview with the home's Administrator confirmed that an employee's vulnerable sector police record check should have been completed within six months of being hired by the home.

Sources: Review of an employee's file; Review of a an employee's vulnerable sector police record checks; and an Interview with the home's Administrator.

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (4) 1. i.
Hiring staff, accepting volunteers
s. 252 (4) The licensee shall require that the person provide the licensee, before the person is hired as a staff member or accepted as a volunteer, with a signed declaration disclosing the following:
1. All the following that occurred with respect to the person:
i. every charge for an offence prescribed under subsection 255 (1) with which the person has been charged,

The licensee failed to ensure that an employee provided, prior to being hired as a staff member, a signed declaration.

Rationale and Summary
A review of an employee's file identified an inconclusive result of their vulnerable sector police record check prior to being hired by the home.

Further review determined that a signed declaration statement was not available on file.

An interview with the home's Administrator confirmed that a signed declaration was required.

Sources: Review of an employee's file; Review of an employee's vulnerable sector police record check; and Interviews with the home's Administrator.