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

Public Report

Report Issue Date: September 11, 2025
Inspection Number: 2025-1129-0003
Inspection Type: Critical Incident
Licensee: Wiigwas Elder and Senior Care
Long Term Care Home and City: Wiigwas Elder and Senior Care, Kenora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11, 2025

The following intake(s) were inspected:
- An intake related to an allegation of physical abuse of a resident by staff.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 (IPAC) Standard

Additional Requirement 11.6 issued by the Director with respect to infection prevention and control.

Specifically, the home failed to post signage for signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual, at the entrances to the home.

Sources: Observations made within the home; and an interview the home's IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

Specifically, expired Alcohol Based Hand Rub (ABHR) was identified in the main entrance and dining room of the home.

Sources: Observations made within the home; and an interview the home's IPAC Lead.

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