

**Original Public Report**

<b>Report Issue Date</b>	June 20, 2022
<b>Inspection Number</b>	2022_1129_0001
<b>Inspection Type</b>	<input checked="" type="checkbox"/> Critical Incident System <input type="checkbox"/> Complaint <input type="checkbox"/> Follow-Up <input type="checkbox"/> Director Order Follow-up <input type="checkbox"/> Proactive Inspection <input type="checkbox"/> SAO Initiated <input type="checkbox"/> Post-occupancy <input type="checkbox"/> Other _____
<b>Licensee</b>	Wiigwas Elder and Senior Care
<b>Long-Term Care Home and City</b>	Wiigwas Elder and Senior Care, Kenora
<b>Lead Inspector</b>	Sylvie Byrnes #627
<b>Additional Inspector(s)</b>	Lauren Tenhunen #196
	<b>Inspector Digital Signature</b>

**INSPECTION SUMMARY**

The inspection occurred on the following date(s): June 6-10, 2022. Off site activities occurred on June 13-14, 2022.

The following intake(s) were inspected:

- One intake related to resident to resident abuse;
- One intake related to an acute respiratory infection (ARI) outbreak;
- Two intakes related to resident elopement.

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours

**INSPECTION RESULTS**

**WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT**

**NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)**

Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee has failed to ensure that a resident was protected from abuse.

#### Rationale and Summary

A resident reported that they had been abused by another resident. Investigation notes indicated that the resident had sustained minor physical injuries from the incident.

The incident caused the resident to feel unsafe in the home.

Sources: interviews with a resident, a PSW, RPN and Director of Care (DOC); record review, investigation notes, home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program".

#627