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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: August 26, 2025

Inspection Number: 2025-1399-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Riverside Glen, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6-8, 11-15, 18-20, 22, 2025
The inspection occurred offsite on the following date(s): August 12, 2025

The following critical incident intake(s) were inspected:

-Intake: #00147532, #00149101, #00155511 - Prevention of Abuse and Neglect
-Intake: #00153960, #00153841, #00148974 - Improper Transfers
-Intake: #00154930, #00150083 - Falls Prevention and Management
-Intake: #00151226 - Responsive Behaviours

The following complaint intake(s) were inspected:

-Intake: #00154700, #00149582, #00154779, #00152332 - multiple resident care concerns
-Intake: #00153026 - concerns with skin and wound management

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's toileting requirements were set out in their plan of care.

A resident's plan of care was updated to include their toileting requirements once the home was made aware of the discrepancy.

Sources: Interviews with staff, care plan with revision history

Date Remedy Implemented: August 14, 2025

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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 immediately report to the Director, alleged improper care of two residents that resulted in risk of harm to the residents.

1) The home initiated an investigation on the day that they were made aware of an allegation of improper care, but the Director was not informed until one business day after.

Sources: interview with staff

2) An incident of improper care occurred and the Director was not made aware until the next business day.

Sources: interview with 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 has failed to ensure that an allegation of resident to resident physical abuse was immediately reported to the Director.

An incident of resident to resident physical abuse occurred, and the Director was not made aware until the next business day.

Sources: interview with staff

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations between two residents including identifying and implementing interventions.

A resident required a specific intervention to minimize the risk of altercations and potentially harmful interactions between and among their co-residents.

The intervention was not applied, this resulted in an altercation between two residents and one of the two residents sustained an injury.

Sources: clinical records, interviews with staff

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was immediately notified upon becoming aware of improper care which had

negatively impacted the resident.

Sources: clinical records, interviews with staff

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Complete a root cause analysis of the circumstances and contributing factors to the incident involving a residents skin and wound concerns:
a) From the analysis, determine gaps in processes, and create and implement an action plan to address the gaps, including follow-up actions with staff, if required;
b) Maintain detailed documentation of the root cause analysis, action plan and implementation of the action plan, including when and who was involved in the implementation.

2) Complete a root cause analysis of the circumstances and contributing factors to the incident involving a residents continence and other care concerns:
a) From the analysis, determine gaps in processes, and create and implement an action plan to address the gaps, including follow-up actions with staff, if required;
b) Maintain detailed documentation of the root cause analysis, action plan and implementation of the action plan, including when and who was involved in the implementation.

3) Develop and implement a process to ensure the Director of Nursing Care is involved when complaints related to resident care are received by the home:
a) Identify which staff require education on the new process, and maintain a record of the education provided that includes the content, the date of the education, who provided the education and all staff members who attended.

Grounds

The licensee failed to ensure that resident two residents were not neglected by the licensee or staff.

As per Ontario Regulation 246/22, "neglect" means 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.

1) A resident was at high risk of skin concerns. A Personal Support Worker (PSW) observed changes to the resident's daily routines and identified that this was related to a new area of altered skin integrity, not previously identified by recent daily skin observations and an assessment by the medical doctor (MD).

A Registered Practical Nurse (RPN) assessed the new area of altered skin integrity but did not document all of their assessment findings.

The Skin and Wound Care Lead assessed the new area of altered skin integrity and provided a treatment plan, but did not take follow-up actions as required by the home's policy.

Weekly assessments showed that the wound was deteriorating. Registered staff did not follow the home's policies and procedures for responding to a deteriorating wound. The resident's SDM and MD were not informed that the resident's wound was deteriorating, and that treatment was ineffective.

The resident required significant skin and wound interventions that negatively impacted their future activities of daily living.

Sources: clinical records, task documentation, skin and wound assessments and referrals, progress notes, the home's Skin and Wound Program Polices and Procedures (Staging Resources, Wound Treatment Order Set, Pressure Injury, Stalled or Deteriorating Wounds), interviews with Skin and Wound Care Lead and other staff

2.a) A resident's plan of care was not reviewed and revised with interventions to meet their toileting needs, despite documentation that showed that the residents continence care plan was ineffective.

On several occasions, the resident SDM reported concerns with the residents continence care management.

Staff at the home were aware that the resident's continence care plan was not effectively meeting the residents toileting needs.

This information was not utilized in the revision of the resident's continence care plan, and no continence care re-assessments were completed.

2.b) A resident's room required additional and frequent housekeeping services.

The Director of Environmental Services (DES) stated that they were aware of housekeeping concerns in the residents room from the residents SDMs and both the part-time and full-time housekeeper on the unit. PSW's were provided the education and tools to do perform housekeeping tasks, despite this, concerns persisted.

When the residents room was not immediately cleaned of bodily fluids, resident and staff safety was at risk related to infection prevention and control risk and it posed a slipping hazard.

2.c) On several occasions, a resident was calling out for assistance and staff did not acknowledge the resident.

The resident had an incident and staff did not immediately respond. The resident sustained a significant injury as a result of the incident.

Family Council also expressed concerns with the lack of response from staff with call bells.

At the time of the inspection, staff did not immediately respond to call bells. Staff were observed prioritizing other tasks that would not put residents at risk if paused - discussing break times, making phone calls, charting, gathering products, leaving the unit, and initiating cares for other residents.

The resident's SDM reported several complaints over many months and the home did not follow their complaint process for responding to all of the complaints.

Sources: observations, clinical records, alarm report, Continence Care Program Policy and Procedures, Family Council Meeting Minutes, Complaint Forms, photos,

complaint emails and interviews the residents SDM and staff

This order must be complied with by October 3, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Written Notification issued to FLTCA, 2021, s. 24 (1) in inspections: #2024-1399-0006 dated December 19 2024; #2023-1399-0007 dated November 27, 2023; #2023-1399-0003 dated February 9, 2023 and #2022-1399-0001 dated December 2, 2022.

Compliance Order (CO) issued to FLTCA s. 24 (1) in inspection #2024-1399-0003 dated July 5, 2024; High Priority CO issued to FLTCA s. 24 (1) in inspection #2025-1399-0001 dated February 21, 2025.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
1) Develop a process in which agency PSW staff are made aware of the transfer status of residents they are responsible for.

2) Educate the agency PSWs on this process, and maintain a record of the education including who is responsible for providing the education, sign off sheets documenting the date and attendees.

3) Ensure that the process remains ongoing for all new agency staff coming to the home.

4) Conduct, at minimum, an audit of ten full mechanical lift transfers per week, performed by PSWs including agency PSWs where possible, on Puslinch and Mapleton Home Areas. Audits are to be discrete and completed for a minimum of four weeks or until compliance is achieved. Audits must include a balance of days, evenings, and night shift and different staff.

5) Maintain a record of the audits in the home, including the dates, who conducted the audits, the staff members being audited, and the results and actions taken in response, if any.

6) Records of items #1-#5 must be made available for Inspectors upon request.

Grounds

The licensee has failed to ensure that staff used safe transferring techniques when assisting three residents.

Two improper and unsafe resident transfers occurred that resulted in pain or injury. A third improper transfer occurred which put a resident at risk of harm.

Sources: observations, care plans, LTCH's Mechanical Lift Policy, LTCH's

investigation outcome letter, interviews with staff

This order must be complied with by October 3, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.