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: January 23, 2026

Inspection Number: 2026-1399-0001

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 dates: January 5, 7-9, 13, 14, 16, 19-23, 2026
The inspection occurred offsite on the following dates: January 6, 12, 15, 2026

The following intakes were inspected:

- Intakes #00161432 and #00164490 complaints regarding the home's Medication Management System.
- Intake #00161433 regarding a complaint about a resident's care and the home's Housekeeping, Laundry and Maintenance Program
- Intake #00161515 regarding a resident elopement
- Intake #00161933 regarding the home's Responsive Behaviour Program
- Intake #00162123 regarding the home's Falls Prevention and Management Program
- Intake #00164585 regarding concerns about the home's Prevention of Resident Abuse and Neglect Program
- Intake #00165016 regarding the home's Infection Prevention and Control Program

- Intake #00167457 regarding a complaint about the improper care of a resident
- Intake: #00168227 regarding a complaint about the home's Whistle Blowing, Retaliation Protection Program

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care
Pain Management
Falls Prevention and Management

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.

A resident displayed responsive behaviours towards another resident causing injury to the resident.

Sources: a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: General Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A resident was administered their pain medications but the medications were not documented as administered.

Sources: a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

A resident who was cognitively impaired, and was unable to communicate their pain levels, was not assessed using a Pain in Advanced Dementia (PainAD), which was designed for resident who were cognitively impaired, and unable to communicate their pain.

Sources: a resident's clinical records, a home's policy and interviews 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.

A resident entered another resident's room and displayed responsive behaviours toward the resident. The resident's plan of care said for staff to redirect the resident from entering other residents' rooms, but the intervention was not implemented.

Sources: review of a resident's clinical records, interviews with staff.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #005 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) Complete a root cause analysis to determine any circumstances and contributing factors resulting in the resident's fall.
2) From the analysis, determine gaps in processes. Create and implement an action plan to address the gaps, including follow-up actions with staff, if required.
3) Maintain detailed documentation of the root cause analysis, action plan and implementation of the action plan, including what the plan was, when it was implemented and who was involved in the implementation.
4) Determine who is required to be aware of the process and educate these individuals.
5) Keep detailed documentation to provide to the Inspector of who was educated, the content of the education, the date(s) it was provided and by whom.

Grounds

A resident was not transferred using safe transferring techniques which resulted a significant change in the resident's condition.

Sources: a resident's clinical records, a CIS report, a home's education document, and interviews with staff.

This order must be complied with by March 23, 2026

COMPLIANCE ORDER CO #002 Administration of drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Complete monthly audits of a resident's specific PRN medications on an identified date. Ensure the audits identify any medication errors made, the date and time of the error, and which staff made the error.

B) For each month that medication incident(s) were identified, ensure that a medication incident report has been submitted in MediSystem.

C) Ensure each medication incident report that was submitted includes an investigation to determine any contributing factors and/or the root cause, and corrective and preventative action plans for these incidents, as per the home's MediSystem policies and procedures. Record the names of individual(s) who participated in this investigation and the findings.

D) Based on the findings of the home's investigations in part C), develop education related to safe medication administration. Consider including components related to

understanding: the combined effects of the specified medications when administered at a low dose, the importance of clarifying a medication order that is unfamiliar or not clear, the importance of directly communicating with the physician if the order cannot be given as prescribed, and the risk(s) associated with exceeding the maximum administration dose that was prescribed. Keep a written record of the contents of the education and who was involved in developing the education.

E) After the education has been developed, educate the staff members who were involved in the medication incidents from Part A, who are currently employed by the home.

Grounds

The home received concerns related to the ordered PRN medications not being administered to a resident as ordered by the physician.

The home investigated the concerns and identified multiple medication errors in the administrations of the ordered PRN medications during an identified time.

During the inspection, it was discovered that there were several other incidents prior to and after the identified time in which the specified PRN medications was administered incorrectly. In addition, it was identified that the resident was administered the specified PRN medications more than what the physician ordered in 24 hours on two identified dates. There were no medication incident reports (MIRS) submitted for the medication incidents identified during the inspection, which resulted in the home not responding to the incidents in a timely manner in accordance to the home's MediSystem policies and procedures.

A resident received their PRN medications incorrectly for several months by various

registered staff, and by not administering the prescribed PRN medications as directed, the medications were not fully optimized for their intended use.

Sources: A resident's clinical records, an electronic mail, the home's medication policy and procedures, and interviews with the home's staff and a service provider.

This order must be complied with by March 6, 2026

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.