

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 10, 2023	
Inspection Number: 2023-1386-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Taunton Mills, Whitby	
Lead Inspector Moses Neelam (762)	Inspector Digital Signature
Additional Inspector(s) Holly Wilson (741755)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): September 20 - 22, 25- 28, 2023</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake related to a Proactive Compliance Inspection (PCI)
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The following **Inspection Protocols** were used during this inspection:

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Residents' and Family Councils
- Food, Nutrition and Hydration
- Medication Management
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Quality Improvement
- Pain Management

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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)

O. Reg. 246/22, s. 19

The Licensee has failed to ensure that the window in a room, that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters.

Rationale and Summary

During the initial tour of the Long-Term Care Home (LTCH), multiple windows were observed. The window in a certain room, was opening 16 cm in the middle and 17 cm in the corner, this was confirmed by the Assistant Director of environmental services (ADES). The window led to the courtyard that was locked, and therefore the outside of the LTCH was inaccessible to the residents. A review and observation of the resident, who resides in the room, indicated that the resident requires assistance daily activities.

In an interview, a PCA, indicated that there was no risk for the resident to elope through the window as they do not have the strength to do so. Furthermore, the window exited towards the courtyard that was locked and prevented residents from leaving the building. In an observation conducted on the following day with the ADES, the window was fixed and opened 9 cm in the middle and 14 cm in the corner.

As a result, there was minimal risk and no impact to the resident due to the window opening another 2 cm.

Sources: Observations; Resident record review; Interviews with ADES and PCA #108[762]

Date Remedy Implemented: September 21, 2023

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WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)

The licensee has failed to ensure that the home's menu cycle includes a choice of other available entrees and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences.

Rational and Summary:

The homes' policy for Meal Service states the following:

- Beverages, including water, juice, and milk, will be offered to all residents unless contraindicated on the People Service Report.
- Each resident will be offered the choice of two meal selections

During the Proactive Compliance Inspection, meal service was inspected. It was observed during a meal service that residents in a home area were given the items on the menu. The residents had access to a "Always On Menu" which includes different items.

The residents were not offered the "Always On Menu", and the residents were not offered a choice of beverages.

An interview with Food Services Worker (FSW), confirmed they placed beverages on the table for each resident on the home area, and did not offer a choice of beverages to the residents.

An interview with PCA #100, confirmed they did not offer a choice of the main entrée between the regular and "Always On Menu".

During an interview, a resident indicated they were given water and juice but was not given the choice of an alternative milk choice. They indicated they would have to ask if they wanted a change in menu, but some residents with cognitive impairment may not know about the "Always On Menu" or beverage choices unless prompted by staff.

Failure to offer a choice of menu items may result in the residents loss of choice.

Sources: September 2023 Meal plan, The home's Meal Service Policy, interviews with staff, careplan of Resident. [741755]