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

Public Report

Report Issue Date: April 30, 2025
Inspection Number: 2025-1386-0003
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Taunton Mills, Whitby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00143439 - Complaint related to improper care of a resident
- Intake: #00143824 - CIR related to a fall incident of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care of a resident was provided to the resident as specified in the plan. Specifically, on a specified date, an intervention was not provided to the resident by a registered staff member according to the plan of care.

Sources: Observation of a resident, the resident's health records and interviews with staff members.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the resident-staff communication and response system (call bell) could be easily seen, accessed and used by residents. On a specified day and time, the call bell in a resident's room was found to be out of reach for the resident.

Sources: Observation and an interview with a staff member.

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

The licensee failed to ensure that a resident's mobility device was appropriate for the resident's condition. Specifically, on a specified date, the resident's foot was not properly positioned while using their mobility device. The Occupational Therapist (OT) indicated the resident required a different mobility device for proper support to accommodate the changes in the resident's condition.

Sources: Observation of a resident and an interview with the OT.

WRITTEN NOTIFICATION: Foot care and nail care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee failed to ensure that a resident received preventative and basic foot

care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint was received regarding a resident not receiving basic foot care services. The resident's health records did not indicate that basic foot care was provided to the resident, including the cutting of toenails. The health record did not reveal any communication to family members of the condition of the resident's toenails or any referrals to advanced foot care.

Sources: resident's health records and interviews with staff members.

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure course by course meal service was provided to a resident. During a meal service, the resident was observed in the dining room with two meal courses placed in front of them. A staff member indicated the resident should have been served course by course.

Sources: Observation of the resident and an interview with a staff member.

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