Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
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Public Report

Report Issue Date: April 30, 2026
Inspection Number: 2026-1386-0003
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 20 - 24, 27 - 30, 2026
The inspection occurred offsite on the following date(s): April 24, 27, 2026

The following intake(s) were inspected:
- Intake: Improper care of a resident
- Intake: Improper care of a resident resulting in hospitalization
- Intake: Improper care of a resident
- Intake: Improper care of a resident
- Intake: Improper care of a resident
- Intake: Improper care of a resident
- Intake: Complainant - Improper care of a resident

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Responsive Behaviours

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;

During observations of a resident it was noted that the residents falls prevention strategies were in place. A review of records and interviews with Program for active living coordinator (PALCoordinator) and a Personal Support Worker (PSW) confirmed that these interventions were not present in the written plan of care. The resident plan of care was subsequently updated by the PALCoordinator.

Sources: Observations in resident room; Clinical Record Reviews; Interviews with PALCoordinator and PSW #104.

Date Remedy Implemented: April 21, 2026

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The plan of care for a resident did not provide clear directions to staff related to care of a medical device and perineal care.

Sources: resident’s clinical records and interviews with Personal Support Worker

(PSW) and the Director of Care (DOC).

WRITTEN NOTIFICATION: Integration of care, assessments

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee did not ensure that staff collaborated in the care of a resident when they were not provided medication for fever and urinary symptoms and staff did not take appropriate action to notify physician or transfer to hospital.

Sources: resident's clinical records and interviews with Nurse Practitioner (NP) and the DOC

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

A resident's written plan of care was not updated to reflect the changes made by the licensee in response to complaints submitted by the resident's family member.

Sources: Critical Incident Report (CIR), resident's clinical record, home's internal investigation file into CIR, interview with DOC

WRITTEN NOTIFICATION: Bed rails

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee did not complete the assessments, observations and bed system evaluation required to minimize risk to the resident prior to the installation of bedrails for them.

Sources: resident's clinical record, home's Bed Entrapment and Bedrail Assessment policy, interviews with DOC and Program for Active Living (PAL) Coordinator

WRITTEN NOTIFICATION: Bed rails

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

A resident had a bed entrapment audit completed prior to bedrail installment. When another device was subsequently installed a bed entrapment audit was not completed in response to the bed system change.

Sources: resident's clinical record, home's Bed Entrapment and Bedrail Assessment policy, interviews with Director of Environmental Services (DES) and the PAL Coordinator

WRITTEN NOTIFICATION: Personal care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee did not ensure a resident received individualized personal care including continence care on a specific date.

Sources: resident’s clinical records, and interviews with PSW) and DOC

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

After sustaining a fall a resident was lifted manually by a PSW. The PSW indicated that the resident was lifted manually because they were having personal expressions (responsive behaviors) and were already getting up. The resident's care plan indicated that a mechanical lift is to be used when the resident is having personal expressions.

Sources: Resident care plan; Interview with PSW

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee did not identify and address triggers for a resident's responsive behaviours related to a physical condition, and consistency required in staffing and routine.

Sources: resident's clinical records, Personal Expression Program Schlegel Villages, Manual: Nursing Section CARE Tab 04-84, interviews with BSO Lead and DOC

WRITTEN NOTIFICATION: Responsive behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee did not ensure that actions were taken to document appropriate interventions including required assessments and reassessments in response to a resident's responsive behaviours.

Sources: resident's clinical records, Personal Expression Program Schlegel Villages, Manual: Nursing Section CARE Tab 04-84, interviews with PSW, BSO Lead and DOC

WRITTEN NOTIFICATION: Notifications re: incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

A complainant was not notified by the licensee of the results of the licensee’s investigation into complaints upon completion of the investigation.

Sources: CIR, resident’s clinical record, home’s internal investigation file into CIR, interview with DOC