

Public Report

Report Issue Date: August 25, 2025
Inspection Number: 2025-1461-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Glendale Crossing, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 11-15, 18, 20-22, and 25, 2025.

The following intake(s) were inspected:

- Intake #00150055 - Complaint regarding alleged neglect of a resident
- Intake #00153701 - Complaint regarding rate reduction and accommodation fees
- Intake #00150434 / Critical Incident (CI) #2979-000038-25 - regarding falls prevention and management
- Intake #00150478 / CI #2979-000039-25 - regarding skin and wound care
- Intake #00150500 / CI #2979-000040-25 - regarding alleged neglect of a resident
- Intake #00154479 / CI #2979-000053-25 - regarding a resident injury
- Intake #00150974 / Follow-up of Compliance Order (CO) #001 from inspection 2025_1461_0003 related to FLTCA, 2021, s. 5, safe and secure home

Previously Issued Compliance Order(s)

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1461-0003 related to FLTCA, 2021, s. 5

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Pain Management
- Falls Prevention and Management
- Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition,

inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5).

The licensee failed to inform the Director within three business days of an incident that caused a significant change in the health condition of a resident for which the resident was taken to hospital.

Sources: Record review of the resident's health care records and CI #2979-000053-25, and a staff interview.

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

- 1) Provide retraining to a staff member on the immediate reporting requirements of suspicions of improper or incompetent treatment that resulted in harm or risk of harm to one or more residents.

2) Maintain a written record of the retraining in the home until this order is complied.

Grounds

The licensee failed to ensure that a person who had reasonable grounds to suspect multiple residents had been subjected to improper or incompetent treatment, which resulted in risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A staff member became suspicious of improper or incompetent treatment by another staff member, but they did not immediately report their suspicion to the home's leadership team. The improper treatment by the staff member risked harm to multiple residents.

Sources: Record review of CI #2979-000039-25, and staff interviews.

This order must be complied with by September 19, 2025

COMPLIANCE ORDER CO #002 Skin and wound care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

- 1) Develop and implement a plan to reassess residents in the home who currently exhibit skin impairments.
- 2) Retrain a group of staff on the skin and wound care program.
- 3) Review and revise a process as needed to ensure that residents with impaired skin integrity receive weekly skin and wound assessments until the skin impairments are resolved.
- 4) Develop a plan for a staff member to oversee the application of the skin and wound care program to ensure that staff are consistently following the process for weekly skin and wound assessments for residents with skin impairments.

Grounds

The licensee failed to ensure when multiple residents exhibited altered skin integrity that they were reassessed at least weekly by a member of the registered nursing staff.

A review of multiple residents' clinical records revealed missing, inaccurate, or discontinued skin and wound assessments. Further review found staff practices related to wound assessments not aligning with clinical expectations. These deviations from the required assessment practices placed multiple residents at risk of wound-related complications.

Sources: Record review of multiple residents' health care records, and interviews with staff.

This order must be complied with by October 17, 2025

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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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



Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator

Long-Term Care Inspections Branch

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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.