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

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

Public Report

Report Issue Date: July 29, 2025

Inspection Number: 2025-1474-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at St. Clair, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-18, 22-25, 28, 29, 2025

The following intake(s) were inspected:

- Intake #00150710/Critical Incident (CI)# 3046-000064-25 relating to an unexpected death of a resident.
- Intake #00151240 relating to a complaint about resident assessments.
- Intake #00151366 /CI# 3046-000067-25 relating to an outbreak.
- Intake: #00151479/ CI# 3046-000069-25 relating to alleged neglect.
- Intake #00151953 relating to a complaint about IPAC practices.
- Intake #00152058 relating to a complaint about IPAC practices.
- Intake #00152374/ CI# 3046-000077-25 relating to fall prevention and management.
- Intake #00152557/ CI# 3046-000078-25 relating to fall prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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 licensee failed to ensure that the written plan of care provided clear directions to the staff for a resident with regards to oxygen therapy.

The residents Medication Administration Record (MAR) reviewed at time of the inspection, indicated a different order for oxygen therapy than the one ordered by the physician following an incident.
In an interview with staff, they confirmed that the directions from the physician should have been written in the MAR.

Sources: A resident's MAR and progress notes, physician orders and interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 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.

The licensee has failed to ensure that a resident was protected from neglect.
As per O. Reg 246/22, s. 7, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

An incident occurred involving a resident, where a staff member performed a skin and wound evaluation, identified an area of altered skin integrity and transferred the resident to hospital. Upon return from the hospital, it was identified that the resident had two areas of altered skin integrity. The home identified that a thorough skin and wound evaluation was not completed.

A staff member did not complete the required assessments as outlined in the home's Return to Village Policy and review the discharge package provided by the hospital. During a record review it was noted that no assessments had taken place since the fall.

A staff member notified the physician of the resident's return and received an order to monitor the resident. During an interview with the staff, it was stated that the resident's vitals were obtained upon return to the home but it was revealed that the resident's oxygen saturation was the only assessed vital sign. The home's policy

states that the registered nursing staff will take and record the resident's vitals once per shift for 24 hours.

Record review revealed that upon return to the home the resident's medications were not reviewed despite a new diagnosis from the hospital visit. In an interview with a staff member, they confirmed that the physician should be called if a resident receives a new diagnosis, so a medication review can be completed. As a result of the inaction, the resident received a scheduled medication in contraindication.

During an interview with the physician they stated that a progress note was made indicating incorrect diagnostic results, based on the information provided by the nurse.

Sources: Hospital discharge paperwork, a resident's electronic and paper chart, Interview with the physician and a staff member, Return to Village Policy,

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that when a resident was sent to hospital, resulting in a

change in transfer status, the Director was informed no later than one business day following the incident.

Sources
Interview with a staff member, review of the Critical Incident Report and a resident's clinical records.

WRITTEN NOTIFICATION: Medical directives and orders - drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (a)
Medical directives and orders — drugs
s. 126. Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and

The licensee failed to ensure that a resident's medications were reviewed following an assessment that determined the resident's condition had changed.

An incident occurred where a resident was transferred to hospital, and upon their return to the home, the resident's medications were not reviewed following a new diagnosis. The resident received a scheduled medication in contraindication to the diagnosis.
A staff member identified that the physician should be notified to review the scheduled medication before administration.

Sources: A resident's medication administration record, interview with a staff

member, electronic resident chart and discharge summary from Windsor Regional Hospital (WRH).