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

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Public Report

Report Issue Date: November 3, 2025
Inspection Number: 2025-1474-0007
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): October 27-31, 2025 and November 3, 2025

The following intake(s) were inspected:

Intake: #00158799 - Critical Incident (CI): 3046-000096-25 - Fall Prevention and Management
Intake: #00159140 - Medication Management & Resident Care and Support Services

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

Resident Care and Support Services
Medication Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to Quality Care and Self-Determination

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee failed to ensure that a medication was administered in accordance with the resident's consent. Review of the resident's Electronic Medication Administration Records (eMars) for a certain month shows that staff administered the medication on two occasions during that month without appropriate consent.

Sources: The resident's clinical records and interviews with a staff and a management team member.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

On certain date, a resident was assisted to the bathroom using an assistive device and was transferred from the bathroom with one person assistance. The resident's plan of care specifies that they use a different type of an assistive device for mobility and require two person assist for transfers. The resident sustained a fall when staff did not provide care in accordance with the requirements set out in the plan of care.

Sources: Interview with staff members, review of the home's internal investigation, the resident's plan of care and quarterly transfer assessment

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that a resident's a medication was administered in accordance with the prescriber's order.
On a certain date, the prescriber discontinued a medication and ordered a different medication to be started. Staff administered the discontinued medication. A member of the management team confirmed that the medication should not have been administered without a physician's order.

Sources: The resident clinical records and interviews with a management team member.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that a medication was administered in accordance with the physician's order. The physician's order included parametres for monitoring a resident's blood pressure (BP) prior to administering the medication. A review of the resident's BP readings during a time period indicated that blood pressure measurements were not taken as ordered. An interview with a member of the management team confirmed that BPs were not obtained prior to medication administration during this time period.

Sources: Sources: The resident clinical records and interviews with management team member