

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 18, 2025

Inspection Number: 2025-1476-0008

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at University Gates, Waterloo

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-12, 15-18, 2025

The following intake(s) were inspected:

- Intake: #00161976 related to Medication Management
- Intake: #00162569 related Residents' Rights and Choices
- Intake: #00163583 related to Infection Prevention and Control

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

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

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residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Staff witnessed two other staff members with a resident who was not appropriately covered while in the hallway of a neighbourhood.

Sources: Critical incident report, Policy: Residents Rights (Tab 01-05), Home's investigation notes, Interviews with staff

WRITTEN NOTIFICATION: Administration of drugs

NC #002 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 did not ensure that a resident was administered a drug in accordance with the directions for use specified by the prescriber.

A) A resident was prescribed a drug. The resident was not administered the drug as prescribed on a specified date.

Sources: Progress notes, Medication order summary report, Policy: Respiratory (Tab 03-07), Interview with staff

B) A resident was prescribed a drug. The resident was found to be receiving the drug at an incorrect dosage on a specified date.

Sources: Progress notes, Medication order summary report, Policy: Respiratory (Tab 03-07), Interviews with staff