

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

Hamilton District

119 King Street West, 11th Floor Hamilton, ON, L8P 4Y7 Telephone: (800) 461-7137

Public Report

Report Issue Date: August 5, 2025

Inspection Number: 2025-1339-0003

Inspection Type: Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Tansley Woods, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29- 31, 2025 and August 1, 5, 2025.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00149426 -IL-0141164-AH/CI 2854-000019-25 related to falls prevention and management.
- Intake: #00150080 -IL-0141476-AH/CI 2854-000020-25 related to infection prevention and control (IPAC).
- Intake: #00151054 -IL-0141907-AH/CI2854-000023-25 related to prevention of abuse and neglect.

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

Infection Prevention and Control Prevention of Abuse and Neglect Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions

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

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to implement appropriate interventions to minimize the risk of potentially harmful interactions between residents.

A resident was exhibiting responsive behaviours. An intervention was implemented; however, it was documented as ineffective.

According to the resident's plan of care, staff were to implement a specific intervention when the resident continued to have responsive behaviours. This was not implemented and as a result, a physical altercation occurred. Another resident sustained injuries.

Sources: resident's clinical notes , CI report, and interviews with staff.