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

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

Public Report

Report Issue Date: July 2, 2025

Inspection Number: 2025-1274-0004

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Winston Park, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-27, 30, 2025 and July 2, 2025

The following intake(s) were inspected:

- Intake: #00145254 and intake: #00145644 related to improper care
- Intake: #00147231 related to fall prevention and management
- Intake: #00147435 related to infection prevention and control

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

Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a Personal Support Worker (PSW) used safe transferring techniques while moving a resident and did not ensure that the assistive device was on the wheelchair. As a result, the resident sustained an injury.

Sources: record review of progress notes, critical incident report, resident observations, PSW interview.

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to promptly assess and administer pain medication when a resident's pain was not relived by initial interventions.

Sources: Review of progress notes, critical incident report, Medication administration record, care plan for resident, pain assessment, observations, interview with RPN and RN.