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
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: June 3, 2024	
Inspection Number: 2024-1465-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Aspen Lake, Windsor	
Lead Inspector Stacey Sullo (000750)	Inspector Digital Signature
Additional Inspector(s) Brandy MacEachern (000752)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22, 23, 24, 27, 2024.

The following intake(s) were inspected:

- Intake: #00107674 - Alleged staff to resident neglect.
- Intake: #00109819 - Alleged neglect to resident by staff
- Intake: #00111965 - Complaint regarding: Medication administration and pain management for resident
- The following intakes were completed in this inspection: Intake #00114909 and Intake: #00111611, were both related to falls with a significant change in condition.

The following Inspection Protocols were used during this inspection:

Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that resident #001's bowel plan was implemented.

Rational and Summary

Resident #001 was identified in a Critical Incident System (CIS) report confirming the bowel protocol was not consistently followed by the registered staff.

On review of resident #001's orders, resident was identified as requiring the bowel protocol on several occasions.

Resident #001's progress note stated the bowel protocol had not been followed.

During an interview with staff who confirmed the nursing staff did not follow resident #001's bowel protocol as ordered consistently and that the expectation for staff were to follow and administer the bowel protocol as ordered.

There was a moderate risk to resident #001 as the bowel protocol was not consistently followed by the nursing staff as ordered.

Sources: Resident #001's EMAR records, progress notes, Critical Incident Report, the home's policy titled: Prevention, Treatment of Constipation, and staff interview.

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