Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 19, 2024
Inspection Number: 2024-1465-0003
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Aspen Lake, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00117390- Allegations of neglect to resident by staff.
- Intake: #00118546- Allegations of neglect to resident by staff.
- Intake: #00118981- Complaint regarding plan of care of resident.
- Intake: #00120999- Allegations of neglect to resident by staff.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan Of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

Rationale and Summary

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

In accordance with FLTCA, 2021 s. 6 (1) (c), the licensee was required to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident.

Specifically, resident #001 had a decline in their health condition that required changes be made to their care plan.

During staff interviews all confirmed that resident #001, had a change to their health status, which was not updated on resident #001's care plan.

There was a low-level risk to resident #001, as the written plan of care did not have clear updated directions for staff and others who provided direct care to the resident.

Sources
Resident #001's care plan, and interviews with staff.

[000750]