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

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Public Report

Report Issue Date: May 22, 2025

Inspection Number: 2025-1465-0003

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): May 6, 7, 8, 9, 13, 14, 15, 20, 2025
The inspection occurred offsite on the following date(s): May 12, 16, 22, 2025
The following intake(s) were inspected:

- Intake: #00142230 -CI 3037-000023-25 Unexpected death of a resident.
- Intake: #00142302 - CI 3037-000024-25 - Alleged neglect of a resident
- Intake: #00142935 - Complaint related to resident care.
- Intake: #00143755 -CI 3037-000028-25 - Alleged neglect of a resident
- Intake: #00143770 - Complaint related to resident care.
- Intake: #00144776 - Complaint related to resident care.
- Intake: #00144779 -Complaint related to resident care.
- Intake: #00144804 - CI 3037-000029-25 Alleged abuse of a resident.
- Intake: #00144807 -CI 3037-000030-25 Alleged abuse of a resident.
- Intake: #00145559 -CI 3037-000032-25 - Fall of resident with injury.
- Intake: #00145954 -Complaint related to resident care.
- Intake: #00145961 -Complaint related to resident care.
- Intake: #00146485 -Complaint related to resident care.
- Intake: #00146626 - CI 3037-000037-25 - Alleged neglect of a resident.

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

Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that a resident had to the right to freedom from verbal abuse.

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences. Review of a resident's medical record indicated that a resident's substitute decision maker called the home to report that another resident had made

comments of a negative nature which made the resident feel threatened on more than one occasion. The resident recounted feeling afraid and hurt by the other resident as a result of that resident engaging in verbal communication of a threatening nature, and of belittling and/or degrading nature.

Sources: Record review of resident's electronic medical record and of the home's complaint forms; interview with resident.

WRITTEN NOTIFICATION: Retraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that a staff member received annual retraining in 2024, in the long-term care home's policy to minimize the restraining of residents, fire prevention and safety, and emergency and evacuation procedures.

In the regulations, as mandated in O Reg 246/22, s. 260. (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The general manager of the home confirmed that this staff member had not completed the expected annual retraining in 2024 in the long-term care home's policy to minimize the restraining of residents, fire prevention and safety, and emergency and evacuation procedures.

Sources: Interview with staff and the General Manager.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

The licensee failed to ensure that a staff member received annual additional retraining in 2024, specifically related to continence care, bowel management, pain management, including pain recognition of specific and non-specific signs of pain.

Pursuant to O. Reg. 246/22, s. 261 (1), For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, continence care, bowel management, pain management, including pain recognition of specific and non-specific signs of pain.

Pursuant to O. Reg. 246/22, s. 261 (2), The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act, annually.

The general manager of the home confirmed that a staff member had not completed the expected annual retraining in 2024 in continence care, bowel management, pain management, including pain recognition of specific and non-specific signs of pain.

Sources: Interview with staff and the general manager.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches to the care of a resident, included reassessment and identification of behavioural triggers that may result in responsive behaviours.

A review of the resident's electronic medical record did not identify triggers and did not indicate that the resident was reassessed for responsive behaviours. Additionally, interviews with staff verified that the resident had not been reassessed by a special resource since the previous year. Furthermore, staff were not able to identify any triggers of the resident's responsive behaviours.

Sources: Record review of resident's electronic medical records; interviews with staff.

WRITTEN NOTIFICATION: Medication management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that when a resident self-administered their medications, it had been approved by the prescriber.

An observation of a resident identified the resident's medications had been left for the resident to take without direct supervision, at their discretion. An interview with the staff member involved indicated this was a common practice and was unable to find supporting documentation in the resident chart.

Sources: Observation of resident; review of resident's electronic medical record; and interview with staff.