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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Feb 10, 2021	2021_563670_0001	024139-20, 025269-20, 025710-20, 000404-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village at St. Clair
1800 Talbot Road Windsor ON N9H 0E3

Name of Inspector(s)/Nom de l’inspecteur ou des inspecteurs

DEBRA CHURCHER (670), KRISTEN MURRAY (731)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 11, 12, 13, 14, 15, 18, 19, 20, 21, 22 and 24, 2021.

The purpose of this inspection was to inspect the following;
Log #024239-20 CIS#3046-000076-20 related to an alleged improper transfer.
Log# 000404-21 CIS#3046-000001-21 related to an unexpected death.
Log# 025269-20 CIS#3046-000078-20 related to a fall with injury.
Log# 025710-20 CIS#3046-000079-20 related to concerns with continence care and feeding.
This inspection was completed concurrently with Complaint Inspection #2020_563670-0036 and Follow Up inspection #2021-563670_002. Inspector #740 was also present for this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Care, the Assistant Director of Nursing Care, four Personal Support Workers, four Registered Practical Nurses and two Nieghbourhood Coordinators.

During the course of this inspection the Inspector observed the overall maintenance and cleanliness of the facility, observed staff to resident interactions, observed meal service, observed the provision of care and reviewed relevant clinical records and internal documentation.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that someone was available to assist resident #003 prior to serving them a meal.

Resident #003 required assistance with meals. Resident #003 was served a meal on a specific date when no one was available to assist the resident with their meal. As a result of this incident, the resident did not receive their meal until approximately two hours after it was served, causing risk to the resident.

Sources: Critical Incident System (CIS) report; resident #003's care plan, progress notes, and dietary assessments; the LTCH's investigation notes; and interviews with PSW #103 and other staff. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 11th day of February, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.