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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Public Report

Report Issue Date: June 6, 2025

Inspection Number: 2025-1474-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at St. Clair, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 5-6, 2025

The following intakes were inspected:

- Intake: #00142343/Follow-up - CO #002 from inspection #2025-1474-0002 relating to FLTCA, 2021 - s. 28 (1) 2. reporting of abuse. Compliance Due Date June 4, 2025.
- Intake: #00148420 / Critical Incident #3046-000052-25 - relating to alleged abuse
- Intake: #00148562 - complaint relating to resident care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1474-0002 related to FLTCA, 2021, s. 28 (1) 2.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Explanation of plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)
Plan of care
s. 6 (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care.

The licensee failed to provide a resident's Substitute Decision Marker (SDM) with an explanation of the residents plan of care when a medication was added relating to a change in their medical condition.
Sources: Resident's clinical records, observations and staff interviews.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed

for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that there was a physicians order obtained prior to administering a medication to a resident. The medication was observed to be administered to the resident. Review of the residents medical records showed no physician orders the medication. Interviews with staff members confirmed there was no orders for the medication and should have been.
Sources: Resident's medical records, observation and staff interviews.

WRITTEN NOTIFICATION: Resident records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure a residents clinical record was kept up to date when their known diagnosis was not documented in their medical records.
Sources: Resident clinical records and staff interviews.