

Ministry of Long-Term Care

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

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 17, 2025

Inspection Number: 2025-1231-0003

Inspection Type:

Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: Erin Mills Lodge Nursing Home, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 3-6, 9-13, and 17, 2025

The following intakes were inspected:

- Intake: #00145462 - Complaint related to continence care, housekeeping, food and nutrition, and prevention of abuse and neglect.
- Intake: #00143585 - Critical Incident (CI) related to falls prevention and management.
- Intake: #00145893 - CI related to falls prevention and management.
- Intake: #00146151 - CI related to improper and incompetent care.

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

Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect

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Falls Prevention and Management

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

The licensee has failed to ensure that the plan of care for a resident set out clear directions to direct care staff regarding their continence plan. On an identified date, the unclear directions affected the resident's continence care as they did not receive care as specified.

Sources: Resident clinical records, home's investigation notes and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following

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has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a person who had reasonable grounds to suspect improper or incompetent care that resulted in a risk of harm to a resident on a specified date was immediately reported to the Director. The Director of Nursing Care (DNC) acknowledged that a Critical Incident (CI) was not reported immediately and was submitted two days later.

Sources: CI report and interview with the DNC.

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's communication and response system was easily accessible by a resident at all times on a specified date.

Sources: A resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Pain management

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program was implemented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the Pain Management policy of the long-term care home was complied with. Specifically, a comprehensive pain assessment was not completed when a resident had a new onset of pain on a specified date.

Sources: Pain Management Program Policy, a resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

IPAC Standard for Long Term Care Homes, revised September 2023, stated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

Between specified dates, an instance occurred when a staff member failed to apply PPE when entering a resident's room while they were in isolation and on additional precautions.

Sources: A resident's clinical records, home's investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

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The licensee has failed to ensure that their acknowledgement of receipt to a written complaint regarding a resident included the date by which the complainant could reasonably expect a resolution.

A complainant submitted a complaint to the home, dated on a specified date and submitted a follow-up complaint with additional concerns two days later. The home combined both submissions into a single complaint record and did not respond within ten business days with a date that the complainant could expect a resolution to all of their concerns.

Sources: Home's complaint binder and an interview with General Manager (GM).

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident was administered medications as per the home's bowel protocols on three identified dates.

Sources: A resident 's clinical records, the home's policy and procedures on the Prevention/Treatment of Constipation, and interview with staff.

WRITTEN NOTIFICATION: Resident records

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NC #008 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 has failed to ensure that a resident's written record was kept up to date at all times. On two identified dates, a resident's written record was not updated with their observed food intake percentage and time of ingestion. In addition, the resident's personal expressions were not updated consistently in their record during March 2025.

Sources: A resident's clinical records, home's investigation notes, and interview with staff.