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

Hamilton District
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Public Report

Report Issue Date: September 12, 2025
Inspection Number: 2025-1231-0004
Inspection Type: 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 date(s): September 2-5 and 9-12, 2025.

The following intake(s) were inspected:

-- Intake: #00149844 - Critical Incident (CI) 2736-000013-25 - Related to resident care and support services;
-- Intake #00154285 - CI 2736-000019-25 - Related to infection prevention and control.

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-

compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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).

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 when open waste receptacles were kept outside of residents' rooms for personal protective equipment (PPE) removal and disposal. This was not in accordance with the IPAC Standard for Long Term Care Homes, revised September 2023, section 9.1 that states Additional Precautions were to be followed in the IPAC program, and shall include (f) Additional PPE requirements including appropriate selection, application, removal and disposal.

The appropriate waste receptacles with lids, including their locations for appropriate PPE removal and disposal, were revised and implemented on September 11, 2025 for residents on additional precautions.

Sources: Observations of rooms on additional precautions, review of order form and in-service records, interview with Assistant Director of Nursing Care (ADNC)-IPAC Lead, and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings' from Ministry of Health, effective February 2025.

Date Remedy Implemented: September 11, 2025

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Specifically, several reports of an identified skin alteration on a resident were not documented by various direct care staff and registered staff for three consecutive days during a certain month.

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

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
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:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the interdisciplinary skin and wound care program is implemented in the home to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions when registered staff did not complete a Skin Concern referral to notify the Skin and Wound Care Lead of a resident's identified altered skin integrity.

Sources: Home's Skin and Wound Care Program, resident's clinical records, and interview with Assistant Director of Nursing Care (ADNC)-RAI.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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).

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.

In accordance with the IPAC Standard for Long Term Care Homes, revised September 2023, it is stated under section 9.1 that Additional Precautions were to be followed in the IPAC program, and shall include (f) Additional PPE (personal protective equipment) requirements including appropriate selection, application, removal and disposal. On a specific date, a care staff member did not follow the proper sequence for removal of PPE when they first removed their gown before their gloves, and did not remove all PPE after providing direct care when exiting a resident's room that was on additional precautions.

Sources: Observations of care staff and interview with Assistant Director of Nursing Care (ADNC)-IPAC Lead.