

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: January 30, 2026

Inspection Number: 2026-1231-0001

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 dates: January 20-23, 27-30, 2026
The inspection occurred offsite on the following date: January 26, 2026

The following intakes were inspected:

- Intake: #00163060 - Critical Incident (CI): 2736-000022-25 - Prevention of Abuse and Neglect
- Intake: #00163661 - CI: 2736-000024-25 - Prevention of Abuse and Neglect

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

Prevention of Abuse and Neglect

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

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A resident's written plan of care did not provide clear directions to staff and others who provide direct care to the resident, as it did not clearly state the number of staff required to provide care support.

Sources: staff interviews, resident's clinical records.

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A resident's care plan for care was not consistent with and did not complement their assessment, this contributed to improper care of the resident by a staff member.

Sources: Critical Incident (CI) #2736-000024-25, staff interviews, resident's clinical records, the home's investigation notes.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

Strategies were not developed and implemented to respond to a resident's behaviors.

Sources: The Personal Expression Program policy, Critical Incident (CI) #2736-000024-25, staff interviews, resident's clinical records.

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COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The inspector is ordering the licensee to ensure compliance with FLTCA, 2021, s. 24 (1) as it pertains to duty to protect residents against abuse and neglect.

Specifically, the licensee shall:

- 1) Conduct an analysis of the incident of resident to resident abuse identified.
- 2) Evaluate the results of the analysis and determine changes or improvements that are required as a result of the analysis.
- 3) Implement the changes or improvements.
- 4) Maintain a written record of the results of the analysis, changes or improvements identified and how they were implemented.

Grounds

The licensee did not protect a resident from abuse by another resident, and a resident from abuse by a staff member on two different dates in 2025.

A) Ontario Regulation 246/22 s. 2 (b) defines sexual abuse as: any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitements d’ordre sexuel”).

A resident's care plan was updated following an incident involving non-consensual contact with another resident. An intervention was implemented at that time to separate the residents.

On a later date, the resident was involved in a second incident of non-consensual

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contact with a different resident.

During the home's investigation, the recipient resident disclosed to members of the management team, that they had been abused by the resident prior to the identified date. As a result, there was an ongoing risk of harm to the resident.

Sources: Critical Incident Report, staff interviews, residents' clinical records, the home's investigation records.

B) Ontario Regulation 246/22 s. 2(b) defines physical abuse as: the use of physical force by anyone other than a resident that causes physical injury or pain.

A resident was demonstrating behaviors during care noted by firmly holding onto a staff's hand. The staff applied force to release the resident's hands, causing harm to the resident.

Sources: Critical Incident Report, staff interviews, resident's clinical records, the home's investigation records.

This order must be complied with by March 30, 2026

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

The inspector is ordering the licensee to ensure compliance with FLTCA, 2021, s. 28 (1) as it pertains to reporting certain matters to the Director.

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Specifically, the licensee shall:

1. Conduct an in-person review and re-training of the following:
 - A) The home's Prevention of Abuse and Neglect policy, specifically addressing sexual abuse, including the definition of sexual abuse and examples of what constitutes sexual abuse
 - B) The home's Mandatory Reporting policy
2. The re-training should be conducted with the following staff:
 - A) All members of the leadership team
 - B) Registered staff employed casually, part-time, and full-time on the home areas
 - C) Personal Support Workers (including medication admins) employed casually, part-time, and full time, on the home areas
3. Document and maintain a record of the education session outlined in part one , including:
 - A) The date and time the review occurred
 - B) The name, title, and signature of who participated in the review
 - C) The name of the person who conducted the review

This record must be readily available for Inspector review.

Grounds

The licensee did not immediately report an allegation of abuse involving several residents, resulting in a risk of harm.

- A) A staff member disclosed to another staff member, that a resident placed their hand on another resident without their consent. Subsequently, a referral was sent to members of the leadership team. However, neither member of the leadership team reported the allegation to the Director as required.
- B) An allegation of resident to resident abuse was reported to a staff member, prior to the date of the reported incident. Subsequently, a staff member informed another staff member on the unit, whose name was undisclosed. The receiving staff member instructed the reporting staff member to maintain observation of the residents to verify

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the occurrence of the act. The staff member did not report the incident to a member of the leadership team, as required, according to the home's mandatory reporting policy. As a result, the alleged incident was not investigated by the home nor was it immediately reported to the Director.

The home became aware of the allegation on a specified date, when a resident disclosed to members of the management team that they had been harmed by the resident in the past, and that they reported the incident to a staff member at that time.

There was ongoing risk of potential harm to the resident.

Sources: Critical Incident Report, staff interviews, residents' clinical records, the home's Mandatory Reporting (Reporting Certain Matters to Director) policy, the home's investigation records.

This order must be complied with by April 29, 2026

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.