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: March 18, 2026
Inspection Number: 2026-1231-0002
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: March 12-13, 16, 18, 2026

The following intakes were inspected:

- Intake: #00169212 - Critical Incident (CI) #2736-000004-26 - Prevention of Abuse and Neglect
- Intake: #00169853 - CI #2736-000005-26 - Prevention of Abuse and Neglect

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A staff member did not document the provision of care set in the plan of care when they

reported care was provided, although the documentation did not correspond with the reported care.

Sources: LTCH's investigation notes, resident's clinical records, staff interviews, Critical Incident Report.

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) 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.

A staff member did not immediately report an allegation of suspected neglect involving a resident, resulting in a risk of harm to the resident.

Sources: Critical Incident Report, LTCH's investigation records, the LTCH's Mandatory Reporting policy, staff interviews.

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;

A staff member placed a resident's communication device in a position that was out of reach.

Sources: LTCHs investigation records, resident's clinical records, staff interview, observations.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

A staff member did not implement a resident's continence plan when assisting the resident with continence care.

Sources: Resident's clinical records, LTCHs investigation records, staff interviews.