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: January 17, 2025

Inspection Number: 2025-1366-0001

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Erin Meadows, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 14-17, 2025

The following intake(s) were inspected:

- Intake: #00125672 [Critical Incident (CI) # 2881-000037-24] - related to unsafe transferring and positioning techniques.
- Intake: #00132136 [CI #2881-000044-24] - related to infection prevention and control.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint that they received concerning the care of a resident in the manner set out in the regulations.

A written complaint was sent to the home related to the care of a resident on a specified date. The home failed to forward the complaint to the Director in the manner set out for in the regulations.

Sources: The written complaint letter, home's Complaints Procedure (December 29, 2022); interview with Assistant General Manager (AGM).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting a resident during a transfer.

A Resident required total assistance with transfers via a mechanical lift. On a specified date, personal support workers (PSWs) unsafely transferred the resident using a mechanical lift, which caused the resident to sustain an injury. Afterwards, PSW staff manually transferred the resident from the floor back to bed.

Sources: Review of a resident's care records, CI #2881-000037-24, investigation notes; interview with AGM.

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) 1.
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the staff followed the falls prevention and management program when a resident was moved off the floor after a fall, prior to the nurse being able to assess them.

O. Reg. 246/22, s. 11 (1) (b) requires the licensee to have, institute or otherwise put in place any program, policy and procedure, and is required to ensure that the program, policy and procedure is complied with.

Specifically, the staff failed to comply with the Falls Prevention and Management Program (August 8, 2024).

On a specified date, a resident fell during a transfer, sustaining an injury. PSWs transferred the resident back to bed prior to the nurse being able to assess the resident for injuries. The home's Falls Prevention and Management Program instructed the staff not to move the resident until they have been cleared by the registered team.

Sources: Review of the investigation notes and the Falls Prevention and Management program; interview with AGM.