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: July 16, 2025
Inspection Number: 2025-1366-0004
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): July 7, 8, 9, 10, 14, 15, 2025
The inspection occurred offsite on the following date(s): July 14, 2025

The following intake(s) were inspected:
-Intake: #00144941 - Critical Incident (CI) 2881-000012-25 - related to improper care of a resident.
-Intake: #00147203 - CI 2881-000013-25 - related to alleged abuse of a resident.
-Intake: #00147980 - CI 2881-000016-25 - related to a fall of a resident resulting in an injury.

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed rails

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee has failed to ensure that where bed rails were used, a resident was assessed and their bed system was evaluated to minimize risk to the resident when they sustained an altered skin integrity due to an injury related to rails.

Source: Resident's clinical records; written email complaint and response letter; The Entrapment Policy; interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident exhibiting altered skin integrity, received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Sources: Review of resident's health records, Skin and Wound Care Program; interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident exhibiting altered skin integrity, received immediate treatment and interventions to promote healing.

Sources: Review of resident's health records, investigation notes, CI; interview with staff.