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

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Public Report

Report Issue Date: August 20, 2025
Inspection Number: 2025-1366-0005
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): August 13, 15, 18-20, 2025.

The following intake(s) were inspected:
-Intake #00149482 was related to Resident Care and Support Services, and Medication Management.
-Intake #00149852 was related to Falls Prevention and Management.
-Intake #00152733 was related to Infection Prevention and Control (IPAC).

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce

transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that immediate action was taken to reduce transmission when a resident who had symptoms of a contagious infection was not placed on isolation precautions.

Sources: A resident's progress notes; interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to ensure that the home's written plan for responding to infectious disease outbreaks for a respiratory outbreak that lasted 22 days, in a specific home area in the home, was followed when the home did not contact public health when two residents had the same symptoms within 48 hours.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the written plan for responding to infectious diseases was complied with. Specifically, the home did not comply with the home's Managing Respiratory Outbreak Policy, which stated that when the case definition for a respiratory outbreak (two or more residents) was met, the Registered Practical Nurse (RPN) would notify the IPAC Lead/charge nurse/designate. The IPAC Lead/charge nurse/designate would phone the Public Health Unit and report the suspect or confirmed outbreak.

Sources: Managing a Respiratory Outbreak Policy, Emails between Public Health and the home, Line Listing related to outbreak; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident's drug was administered in accordance with the directions for use specified by the prescriber.

Sources: A resident's progress notes, Medication Incident Form; and interview with staff.