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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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 13, 2023	
Inspection Number: 2023-1231-0002	
Inspection Type: Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Erin Mills Lodge Nursing Home, Mississauga	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.04.27 20:52:58 -04'00'
Additional Inspector(s) Helina Leung (741076)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, April 3, 4, 5, and 6, 2023.

The following intake(s) were inspected:
Intake: #00018300 – (Critical Incident [CI]#2736-000002-23) was related to falls.
Intake: #00018516 – (CI#2736-000003-23) – was related to alleged neglect.

The following intakes were completed in this inspection:
Intake: #00002343 – (CI#2736-000009-22); #00002349 – (CI#2736-000008-22) #00004892 – (CI#2736-000011-22); #00005248 – (CI#2736-000003-22) and #00015454 – (CI#2736-000020-22) were related to falls.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was not neglected by the licensee or staff.

Rationale and Summary
A Critical Incident (CI) was submitted to the Ministry related to alleged staff to resident neglect. The home received a complaint prior, regarding four residents that were not being toileted on the day shift resulting in impaired skin integrity. The complainant reported to the home that these residents were soiled, and their skin was irritated and red.

Upon receiving the complaint, the home commenced an investigation. Assessments were conducted on all the residents involved and one resident developed altered skin integrity as a result of staff neglecting their care needs.

Sources: Resident's electronic health records, home's investigation notes, CI #2736-000003-23, Abuse training records and attendance, the home's Abuse policy #04-06, titled, "Prevention of Abuse and Neglect", interviews with GM and other staff. [698]

WRITTEN NOTIFICATION: Doors in a Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary
On April 4, 5 and 6, 2023, doors on one resident home area leading to the tub room, storage room and

clean utility room were left open.

Staff members stated these rooms were non-residential areas and their doors should have been locked to restrict resident access, but they were not.

After the non-compliance was brought to the home's attention, staff did not adhere to the policy and the above-mentioned doors were observed to be open throughout the inspection.

There was no impact and risk to residents was low as a result of the non-compliance.

Sources: Observations; policy review and interviews with staff. [698]