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 4, 2025

Inspection Number: 2025-1231-0001

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 date(s): February 21, 24-28, and March 3, 2025

The following intake(s) were inspected:

- Intake: #00133798 - Critical Incident (CI) - Falls Prevention and Management
- Intake: #00138996 - CI - Infection Prevention and Control

The following intake(s) were completed during the inspection:

- Intake: #00128479 - CI - Infection Prevention and Control
- Intake: #00133762 - CI - Infection Prevention and Control

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to provide for strategies to reduce or mitigate falls, when a resident was portered to the shower room by a student without supervision of their preceptor.

This led to the fall of the resident contributing to an injury.

Sources: interviews with staff, the home's student handbook, resident's clinical records, Critical Incident (CI). [000762]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that where the Regulation required the licensee of

a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for long-term care homes, Standard 9.1, the licensee was required to ensure that proper use of Personal Protective Equipment (PPE), including appropriate selection, and removal was followed.

On a date in 2025, a staff member did not follow the proper sequence for removal of PPE, and did not remove all PPE after providing direct care and leaving a resident's room.

On a date in 2025, a staff member, did not follow the proper use of Contact Precaution PPE when a long sleeved gown was not worn during care for a resident.

Sources: observations; residents' clinical records, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023), and interviews with staff. [000762]

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure guidance issued by the Chief Medical Officer of

Health was followed in the home.

In accordance with the Chief Medical Officer of Health (CMOH) Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Section 3.12, the licensee was required to ensure that common areas with visibly dirty surfaces were to be cleaned and disinfected immediately.

The dining room tables were not cleaned and disinfected at the home's scheduled times after meal service, with food debris noted post meals on two different dates in 2025. The home area was in outbreak, and other residents were using the dirty dining tables for communal use.

Sources: Dining room observations, Job routines, the home's Sanitation and Infection Control: Cleaning and Sanitizing policy, revised January 2017, Chief Medical Officer of Health (CMOH) Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, and staff interviews. [000762]