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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Original Public Report

Report Issue Date: August 30, 2024	
Inspection Number: 2024-1366-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Erin Meadows, Mississauga	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 12-16 and August 19-22, 2024

The following intake(s) were inspected:

- Intake: #00117259- Complaint related to prevention of abuse and neglect, resident care and support services, and resident rights.
- Intake: #00119404- Critical Incident (CI) related to infection prevention and control (IPAC).
- Intake: #00116436- CI related to falls prevention and management.
- The following intake(s) were completed in this inspection: Intake: #00121173- CI related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
On a specified date, observations in a resident's room indicated two different transfer postings on the wall above the resident's head of bed. A staff member acknowledged that the postings in the room were unclear directions for staff and

that one of the transfer instructions posted should no longer be posted and was removed the following day.

Sources: Observations, a resident's clinical records, and interviews with staff.

Date Remedy Implemented: On a specified date

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented.

Rationale and Summary
A resident had a specified intervention with a specified frequency. Documentation in Point of Care (POC) demonstrated that staff were documenting the provision of this care task at the same time or as late entries on multiple occasions. The Assistant Director of Nursing Care (ADNC) explained that POC documentation should be completed after each time the specified intervention was performed, in order to accurately demonstrate when the care was provided.

Failure to document provision of care in a timely fashion may have resulted in care not being provided as per the resident's plan of care.

Sources: Resident clinical records and interviews with staff.