Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 13, 2022
Inspection Number 2022_1032_0002
Inspection Type
☐ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee

Mississauga Long Term Care Facility Inc.
26 Peter Street North Mississauga ON L5H 2G7

Long-Term Care Home and City
Mississauga Long Term Care Facility Inc.
26 Peter Street North Mississauga ON L5H 2G7

Lead Inspector
Nicole Ranger (189)

Inspector Digital Signature
Nicole S Ranger
Digitally signed by Nicole S Ranger
Date: 2022.07.14 14:17:14 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 10, 13, 2022.

The following intake(s) were inspected:

- Log # 010962-22 (Follow-up) related to Administrator in the home.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 212 (1) (1)	2022_1032_001	001	189

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

- Infection Prevention and Control (IPAC)
- Safe and Secure Home
- Staffing, Training and Care Standards

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INSPECTION RESULTS

WRITTEN NOTIFICATION CRITICAL INCIDENT REPORTING

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non compliance with: O. Reg 246/22 s. 115 (3) 2.

The licensee has failed to ensure that the Director is informed no longer than one business day after a breakdown of major equipment or a system in the home.

Rationale and Summary:

O. Reg 246/22 s. 115 (3) requires every licensee of a long-term care home to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

ii. a breakdown of major equipment or a system in the home.

On June 10, 2022, Maintenance Lead #106 reported to the inspector that the central air conditioning unit was not functional since June 3, 2022, and required repairs. As of June 13, 2002, the repairs were not completed, and the home did not inform the Ministry of Long Term Care (MLTC) Director of the breakdown of the air conditioning equipment in the home.

Sources: Observations on June 10, 13, 2022, Critical Incident System (CIS) portal, interview with Maintenance Lead #106.
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COMPLIANCE ORDER [CO#001] AIR TEMPERATURE

NC#002 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 24 (2)(3)(4)(5)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg 246/22 s. 24 (2)(3)(4)(5).

The licensee must be compliant with O. Reg 246/22 s. 24 (2)(3)(4)(5).

Specifically, the licensee must:

Ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

(3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

(4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom that is not served by air conditioning, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

(5) The licensee shall keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

Grounds

Non compliance with: O. Reg 246/22, s.24 (2)(3)(4)(5).

The licensee has failed to ensure that air temperature is measured and documented in required areas of the home.

Ontario Regulation 246/22 s. 24 (2)(3)(4)(5) sets out requirements for monitoring temperatures in Long Term Care homes (LTC). Each day throughout the year, licensees are required to ensure that temperature is measured and documented in writing, for required areas of the home.

Rationale and Summary:

On June 10, 2022, Maintenance Lead #106 reported to the inspector that the central air conditioning unit was not functional since June 3, 2022, and required repairs. Maintenance Lead #106 was unable to provide daily air temperature documentation for periods in 2021 and 2022, and acknowledged the home does not take daily air temperature readings in the required areas.

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Additional temperature monitoring requirements apply for resident bedrooms that are not served by air conditioning. For every resident bedroom that is not served by air conditioning, licensees must ensure that the temperature is measured in the room once a day in the afternoon between 12 and 5 p.m. and documented in writing.

Maintenance lead #106 reported that the central air conditioning unit provides cooling to all hallways and six residents' rooms in the home. The inspector requested air temperature readings for these areas as they were not receiving air conditioning. As of June 13, 2002, the repairs to the central air conditioning were not completed. Maintenance Lead #106 was unable to provide air temperature documentation and acknowledged they did not take daily temperature readings in the affected hallways and residents' rooms.

Sources: Observations on June 10, 13, 2022, review of maintenance logs and interviews with Maintenance Lead #106, Acting Administrator #101, and Director of Care #100.
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This order must be complied with by July 8, 2022