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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 09, 2022	
Inspection Number: 2022-1032-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Mississauga Long Term Care Facility Inc.	
Long Term Care Home and City: Mississauga Long Term Care Facility, Mississauga	
Lead Inspector Nital Sheth (500)	**Inspector Digital Signature** Nital Sheth Digitally signed by Nital Sheth Date: 2022.12.12 10:10:31 -05'00'
Additional Inspector(s) JulieAnn Hing (649)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 28, 30, October 3-7, 11-12, 2022.

The intake related to Mississauga LTC Proactive Inspection was inspected.

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

Infection Prevention and Control
Medication Management
Skin and Wound Prevention and Management
Falls Prevention and Management
Pain Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils

Prevention of Abuse and Neglect
Residents' Rights and Choices
Quality Improvement
Safe and Secure Home

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)

FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:
The resident's written plan of care did not reflect the right size of their incontinent product.

A Registered Nurse (RN) confirmed the right size of an incontinent product for resident #012, however the resident was observed with a Personal Support Worker (PSW) using an incorrect sized incontinent product.

Failure to update the correct incontinent product size in the resident's written plan of care put them at risk for receipt of an incorrect size.

Sources: Observation of resident #012, review of resident #012's written plan of care, interviews with an RN, Director of Care (DOC).

Date Remedy Implemented: October 7, 2022, 01:49 p.m. [649]

WRITTEN NOTIFICATION: NUTRITION MANAGER

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 81 (4)

The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under O.Reg.246/22, s. 81 (5), without including any hours spent fulfilling other responsibilities.

Rationale and Summary:
A list of the Food Service Supervisor (FSS) and Nutrition Manager's worked hours (February 16 to June 30, 2022) provided by the licensee indicated that for seven weeks the onsite hours were less than the required number of hours per week calculated according to O. Reg.246/22, s. 81 (5).

The licensee calculated required number of hours for the FSS and NM positions, based on the average number of residents (38) in the home; the required number of hours is 12.16 per week. The FSS and NM worked on average 7.5 to 12 hours for the seven identified weeks which is 4.66 to 0.16 hours less than the required weekly hours (12.16).

Sources: FSS and NM's work schedules and paystubs, document which detailed the number of FSS and NM's hours calculated by the licensee, interviews with the Acting Administrator, Assistant Administrator, DOC, and FSS. [500]

WRITTEN NOTIFICATION: FAMILY COUNCIL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 65 (7) (b)

The licensee has failed to ensure that if there was no Family Council, the licensee should convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

Rationale and Summary:
The home did not convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council. The home's policy did not include this requirement.

Sources: Policy (Family Council, reviewed October 7, 2022), and interview with the Acting

Administrator. [500]

WRITTEN NOTIFICATION: MEDICATION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 123 (2)

The licensee has failed to comply with their medication policy for destruction and disposal of all drugs in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that drugs to be destroyed were stored in a locked storage bin in the DOC's office.

Rationale and Summary:
Specifically, staff did not comply with the home's Drug Destruction and Disposal policy that indicated medications for destruction should be stored in a locked storage bin in the DOC's office.

Observations of non-denatured medications in an unlocked disposal bin in the DOC's office was brought to the home's attention. This medication disposal bin remained unlocked and previously discarded medications accessible until 12 days later.

Failure to lock the lid on the medication disposal bin posed the risk of previously discarded medications being accessible.

Sources: Observations made throughout the course of this inspection, review of the home's Drug Destruction and Disposal policy (last reviewed date February 24, 2021), interviews with Acting Administrator and DOC. [649]

WRITTEN NOTIFICATION: MEDICATION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 123 (1)

The licensee has failed to comply with their controlled medication shift count policy for drugs used in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that all controlled medications were counted at each shift change by two registered staff at identified times of 0700 to 1500, 0800 to 1400, 1500 to 2300, and 1600 to 2200 hours, since shift times differed.

Rationale and Summary:
Specifically, staff did not comply with the home's controlled medication shift count policy that indicated narcotics were to be counted at each shift by two registered staff.

Observation of the controlled medications count indicated that a resident's as needed (PRN) narcotic medication was last counted two days prior; several shift counts had been missed.

Failure to complete counts of controlled medication at each shift change by two registered staff posed the risk for potential discrepancy with the count.

Sources: Observation of all controlled medications in the narcotic bin on the first-floor home area, review of the home's policy titled Controlled Medication Shift Count policy (last reviewed date June 15, 2022), interviews with RN and the DOC. [649]]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 20 (b)

The licensee has failed to ensure that resident-staff communication and response system was on and working at all times in a resident's washroom.

Rationale and Summary:
Observation with a PSW showed that the resident 's call bell in their washroom was not working. When the button was pushed no sound was heard in the hallway, and the light on the call bell panel did not come on.

The DOC acknowledged that the resident's washroom call bell should be working at all times.

Failure to ensure that the call bell was functioning at all times put the resident at risk of calling for assistance from the washroom and receiving no response.

Sources: Observation of call bell function in the resident's washroom with the PSW, and interview with the DOC. [649]

COMPLAINCE ORDER CO #001 INFECTION PREVENTION AND CONTROL (IPAC)

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The licensee has failed to comply with: O. Reg. 246/22 s. 102 (2) (b)

The licensee shall:

(a) Retrain new hires (two identified staff) on all eight required infection prevention and control (IPAC) topics as per O. Reg 246/22, s. 259 (2).
(b) Review and update the home's Coronavirus (COVID-19) policy related to working in an outbreak situation so it provides clear direction to all staff, regarding the use of personal protective equipment (PPE) required to enter a resident's room on precautions.
(c) Retrain all PSWs, registered staff (RPN and RN), Maintenance and Housekeeping staff on the home's revised COVID-19 policy including expectation on (PPE) use for residents on precautions.
(d) Maintain a record of the training provided, including the date, staff signed attendance, and who provided the training.

Grounds
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

(i) The licensee has failed to ensure that staff used PPE in accordance with additional precautions, and home's COVID-19 policy provided conflicted directions from these requirements.

Review of the home's policy and procedure for COVID-19, related to working in an outbreak situation directed staff to conduct a risk assessment, to determine if they could guarantee that they will not be touching anything belonging to the resident. If the risk assessment indicated that they may come into contact with the resident, then they should don a gown and gloves. The policy also stated that if an entire home area was in outbreak with multiple resident rooms on precaution, then a N95 mask must be worn by all staff and caregivers at all times.

Rationale and Summary:
On various occasions, the inspector observed a PSW, maintenance and housekeeping staff not following additional

precautions signages and observed with inappropriate PPE in the residents' rooms on additional precautions when the home was in COVID-19 outbreak. The inspector observed that the gown disposal bins were halfway in two residents' rooms.

This DOC advised that the signage was incorrectly posted and corrected it.

Failure of staff to follow posted additional precautions signage prior to entering residents' rooms, conflicting directions in the home's COVID-19 policy, and gown disposal bins halfway inside residents' rooms increased risk of transmission of infection.

(ii) The licensee has failed to ensure that staff members, a visitor, and inspector were actively screened prior to being allowed to enter the home.

According to the Ministry of Long-Term Care (MLTC) COVID-19 Guidance document for long-term care homes (LTCH) in Ontario all individuals were to be actively screened for symptoms and exposure history before they were allowed to enter the home. Visitors and staff must be actively screened once per day at the beginning of their shift or visit.

Rationale and Summary:
Five staff members, a visitor and inspectors were observed not actively screened prior to entry to the home.

Failure of staff to actively screen individuals for sign and symptoms of COVID-19 prior to entry to the home increased resident exposure risk.

(iii) The licensee has failed to ensure that IPAC self-audits were completed at a minimum of every two weeks when not in COVID-19 outbreak, and at a minimum of once a week when in outbreak.

According to the MLTC COVID-19 Guidance document for LTCH in Ontario, Infection Prevention and Control (IPAC) self-audits must be completed at a minimum of every two weeks unless when in an outbreak, it must be completed at a minimum of weekly. The home had submitted a Critical Incident System (CIS) report to the MLTC on September 16, 2022, reporting a COVID-19 outbreak.

Rationale and Summary:
IPAC self-audits were not completed at the required frequency mentioned above. IPAC self-audits were not completed on September 7, 2022, when the home was not in outbreak, and not completed on September 27, 2022, when the home was in a COVID-19 outbreak.

Failure of the home to complete IPAC self-audits at the required frequency increased the risk of IPAC practice concerns not being identified timely.

(iv) The licensee has failed to ensure that newly hired staff received training on all eight required IPAC topics as indicated in O. Reg 246/22, s. 259 (2).

Rationale and Summary:
(a) IPAC training records were randomly selected and reviewed for two newly hired staff. A Housekeeper and a PSW had not completed training on all eight required IPAC topics.

Failure of the home to ensure that newly hired staff completed IPAC training increased the risk of new staff not following IPAC practices.

Sources: Observations related to the home's IPAC practices, home's COVID-19 policy and procedure last reviewed on September 8, 2022, MLTC COVID-19 Guidance document for LTCH in Ontario, IPAC self-assessment audits, training records for the Housekeeper and PSW, interviews with IPAC lead, Screeners, and other relevant staff. [649]

This order must be complied with by January 16, 2023

Ministry of Long-Term Care
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5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.