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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 10, 2024	
Inspection Number: 2024-1032-0002	
Inspection Type: Critical Incident	
Licensee: Mississauga Long Term Care Facility Inc.	
Long Term Care Home and City: Mississauga Long Term Care Facility, Mississauga	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature**
Additional Inspector(s) Sarah Valente (000847)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-28, April 2-3, 2024.

The following intake(s) were inspected:

- Intake #00099579 was related to falls prevention and management.
- Intake #00104766 was related to falls prevention and management.
- Intake #00105035 was related to infection prevention and control.
- Intake #00107627 was related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the door leading to the stairwell on the second floor was kept closed and locked when a resident was not being supervised by staff.

Rationale and Summary
On an identified date, the resident fell while going down the stairs unsupervised. The resident sustained injuries and was sent to the hospital.

The administrator identified that the resident was able to access the stairwell which was a non-residential area, as the resident had the access code for the door leading

to the stairwell.

After the fall, the home changed the access code for the door to the stairwell. However, as a result of the fall, the resident sustained injuries.

Sources: A resident's progress notes, Home's Investigation Package; interview with the Administrator.
[748]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to ensure that a COVID-19 outbreak declared on an identified date, was reported using the Ministry's after- hours emergency contact.

Rationale and Summary
According to s.115 (1) of Ontario Regulation (O.Reg) 246/22, every licensee of a long-term care home was to ensure that the Director was immediately informed of an outbreak.

The home submitted a Critical Incident Report (CIS) a day after the outbreak was declared, but did not report the outbreak using the after-hours emergency contact

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when the outbreak was declared on the identified date.

Sources: CIS report; interview with the Administrator.
[748]