



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2013	2013_189120_0069	H-000635- 13	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.

400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

Long-Term Care Home/Foyer de soins de longue durée

SPECIALTY CARE MISSISSAUGA ROAD

4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 3, 2013

During the course of the inspection, the inspector(s) spoke with administrator, Director of Care and maintenance person regarding critical incident #2956-000034-13 related to the home's maintenance program and emergency plans.

During the course of the inspection, the inspector(s) observed several resident washrooms, reviewed emergency drill evaluations, generator test logs and inspection reports, loss of power policies and procedures, and maintenance records and external contractor reports.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:

1. Plan activation. O. Reg. 79/10, s. 230 (5).

2. Lines of authority. O. Reg. 79/10, s. 230 (5).

3. Communications plan. O. Reg. 79/10, s. 230 (5).

4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :



1. The emergency plan, specifically related to a loss of power, does not provide information regarding the equipment vital for the emergency response being set aside and readily available at the home. The "Electrical Power Failure" plan identifies that a generator is available in the home to activate, but does not describe what services the generator will operate, location of the service(s) and for how long.

The administrator and maintenance person for the home were both aware of the generator's capability during a power loss situation (based on a recent power loss in June 2013) but could not provide any written documentation that was also available to other staff as a reference. [s. 230(4)3]

2. The emergency plans dealing with but not limited to the loss of essential services such as power and heating do not address components related to;

2. Lines of authority

4. Specific staff roles and responsibilities

Policy XVIII-H-10.40 titled "Electrical Power Failure" and XVIII-H-10.60 titled "Total Loss of Heating System". Staff roles and responsibilities were not all included in the above two plans, identifying only the role of the administrator, General Manager or maintenance person. In the event of heat loss or power loss, staff from all departments would be involved such as dietary, nursing, housekeeping, laundry, administrative and activation staff. Each department would be required to ensure that certain services are managed in the event of a power loss or loss of heating and would require clear instructions should the designate not be able to convey any directions. As additional staff member roles are not available in the plans, only a partial line of authority was included in the plans. [s. 230(5)]



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Issued on this 7th day of October, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B. Sosnik