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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date August 23, 2022
Inspection Number #2022_1387_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☒ Other IPAC and Cooling Requirements

Licensee
Centennial Place Millbrook Inc.

Long-Term Care Home and City
Centennial Place
2 Centennial Lane North, Millbrook, Ontario, M5J 2G2

Lead Inspector

Lynda Brown (111)

Additional Inspector(s)
Katelyn Chopee (741774)
Laura Crocker (741753)

Inspector Digital Signature

Lynda Brown
Digitally signed by Lynda Brown
Date: 2023.07.31 12:22:57 -04'00'

AMENDED INSPECTION REPORT SUMMARY

Under WN #004, item one of two was removed.
Under WN #005, item one evidence was altered.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 6, 8-10, 13, 15-17, 20, 22-23, 2022.

The following intake(s) were inspected:
- Log # 001101-22 (CI) & Log # 007143-22 (CI) related to a disease outbreak.
- Log # 005851-22 (CI) related to missing or unaccounted for controlled substance.
- Log # 012515-21 (CI), Log #018285-21 (CI), Log #017781-21 (CI), Log # 010472-21 (CI), Log # 010095-21 (CI) and Log #004720-22 (CI) related to resident to resident abuse.
- Log # 004777-22 (Complaint) related to resident to resident abuse.

The following Inspection Protocols were used during this inspection:

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION POLICIES TO BE FOLLOWED

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

Non-compliance with: O. Reg. 79/10 s.8(1)(b)

The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Rationale and Summary

Under O.Reg. 79/10, s. 136(2)1, The drug destruction and disposal policy must also provide for the following: That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

Resident #012 had a number of narcotic analgesics discontinued and were placed into the drug destruction box by the ADOC and witnessed by an RPN. The RPN confirmed the drug destruction box had been very full at the time. A number of weeks later, during the drug destruction with an RN Supervisor and the Pharmacist, they discovered that a number of narcotic analgesics for resident #012 were unaccounted for. The narcotic drug destruction box was located in a medication room and locked with two keys. There was no sign off record located at the drug destruction box, as per the home's drug destruction policy. The ADOC indicated although the charge nurse on that unit had access to the medication room, the keys to the drug destruction box were kept with RN Supervisors. The ADOC indicated the drug destruction was to be completed when either the box was full or when the pharmacist came in to complete drug destruction. The drug destruction box keys were now kept with the DOC and a camera was placed in the medication room as a result of the medication incident.

Failing to ensure that the narcotics and controlled substances were stored and disposed of safely and securely within the home, until the destruction of the drugs occurred, resulted in a number of narcotic analgesics being unaccounted for.

Sources: CI, Medication Destruction and Disposal policy, medication incident report, Individual and narcotic shift count records, observation of drug destruction bin and interview of staff. [111]

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WRITTEN NOTIFICATION REPORTS RE: CRITICAL INCIDENTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.107(1)5

The licensee has failed to ensure that the Director is immediately informed, in as much detail as possible in the circumstances, of a disease outbreak of public health significance or communicable disease as defined in the *Health Protection and Promotion Act*.

Rationale and Summary

A disease outbreak was declared by Public Health (PH) that included a number of suspected and confirmed resident cases. The report to the Director was submitted two days after the outbreak was declared. The DOC confirmed the disease outbreak was not reported to the Director until two days later**.**

Sources: CI and interview of staff. [111]

WRITTEN NOTIFICATION IPAC PROGRAM

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 229 (5)(a)(b)

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director, and the symptoms are recorded, and that immediate action is taken to reduce transmission, isolate residents and place them in cohorts as required.

Rationale and Summary

The home was declared in a disease outbreak by Public Health (PH). Resident #003, #004 and #005 all developed sign and symptoms of a respiratory infection on a specified date. Documented assessments were not completed on every shift as required. There was also no indication when their isolation was discontinued.

The Administrator indicated that the registered staff worked 12 hour shifts and would not necessarily be documenting every eight hours for those residents on isolation with respiratory symptoms. The home's outbreak policy indicated that registered staff would review the resident's health status each shift. On the unit where the outbreak was declared, nursing staff worked eight-hour shifts.

Failing to monitor residents for symptoms of infection on every shift and immediate actions taken, can lead to symptom progression or improvements not being detected and transmission of infections to other residents.

Sources: CI, Public Health line listing, progress notes for resident #003, #004 and #005, Outbreak Management policy and interview of staff. [111]

WRITTEN NOTIFICATION POLICE NOTIFICATION

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.98

The licensee has failed to ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary

Resident #014 was a recipient of abuse by resident #013 and resulted in an injury to resident #014. The report to the police was not submitted until the day after the incident occurred. An RN confirmed the report to the police was submitted the day after the incident occurred.

Failing to immediately report a witnessed resident to resident abuse incident, may lead to delayed investigations.

Sources: CI, home's investigation, home's investigation, health record of resident #013 and #014 and interview of staff. [111]

WRITTEN NOTIFICATION POLICY TO PROMOTE ZERO TOLERANCE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s.20(1)*

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Rationale and Summary

1.There was a witnessed resident to resident abuse incident that occurred involving resident #013 towards resident #014. The incident was witnessed by a PSW who reported the incident to an RPN and an RN. The Administrator indicated witness statements were completed using the resident incident form. There was no documented evidence of any witness statements, or the resident incident form completed for this incident.

2. Resident #002 was witnessed by two PSWs involved in abuse towards resident #001. Resident #001 appeared upset and afraid at the time of the incident. Resident #001 was

cognitively impaired and unable to consent. The registered staff were to follow specific procedures when the abuse occurred. The incident was reported to an RPN and an RN. Both the RPN and RN confirmed that the incident was abuse and that the procedures were not followed.

Failing to follow the zero tolerance of abuse policy related abuse, may lead to residents not being appropriately assessed after the abuse has occurred. Failing to complete investigations as per the home's policy, can lead to investigations being incomplete.

Sources: two CI's, health records of resident #001, #002, #013 and #014, observations/interviews of resident #001 and #002, home's investigation, Abuse and Neglect-Zero Tolerance policy, Abuse and Neglect-Investigation Policy, Resident intimacy and sexuality policy and staff interviews. [111]

WRITTEN NOTIFICATION REPORTS OF INVESTIGATION

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.23(2)

The licensee has failed to ensure the report to the Director included the results of every investigation undertaken under clause (1) (a) and every action taken.

Rationale and Summary

1. The Director was informed of a witnessed, resident to resident abuse incident involving resident #010 and #011 that resulted in an injury to resident #010. The incident was witnessed by an RPN. There was a second altercation that occurred shortly after and was witnessed by a PSW, but no injury was noted. There was no documented evidence when the investigation was completed, the results of the investigation and the Director was not informed of the results of the investigation.
2. The Director was informed of a different witnessed, resident to resident abuse incident involving resident #010 and #011 and resulted in an injury towards resident #010. The incident was witnessed by a security guard. There was a second altercation that occurred a short time later and was witnessed by a Life Enrichment Aid (LEA) but no injury was sustained. There was no documented evidence when the investigation was completed, the results of the investigation and the Director was not informed of the results of the investigation.
3. The Director was informed of a witnessed, resident to resident abuse incident between resident #013 towards resident #014. The report was not amended to include the results of the investigation. The DOC confirmed the investigation was completed and the report to the Director had not included the results of the investigation.
4. The Director was notified of a witnessed, resident to resident abuse incident between resident #013 towards resident #015. The report to the Director was not amended with the results of the investigation. The DOC confirmed the investigation was completed and the report to the Director had not been amended with the results of the investigation.

5. The Director was notified of a suspected resident to resident abuse incident that occurred between resident #013 towards resident #016 and resulted in an injury. Resident #016 was later transferred to hospital for assessment and treatment of the injury. The report to the Director had not been amended with the outcome of the investigation. The DOC confirmed the report to the Director provided an update regarding resident #016 but the report did not include the results of the investigation.
6. The Director was notified of a witnessed incident of resident to resident abuse by resident #002 towards resident #001. The report to the Director did not include the results of the investigation. The home's investigation indicated the investigation was completed on a specified date. Both the DOC and Administrator confirmed the results were not provided to the Director. The Administrator indicated they were unaware the Director was to be notified of the outcome of the home's investigations upon completion.

Failing to notify the Director of the results of the home's investigation into each incident of resident to resident abuse leads to investigations not being completed.

Sources: six CI's, home's investigations and interview of staff.[111]

WRITTEN NOTIFICATION POLICY TO PROMOTE ZERO TOLERANCE-CONTENTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 25(2)(e)

The licensee has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents, contain procedures for investigating and responding to alleged, suspected or witnessed abuse, including sexually abused residents.

Rationale and Summary

The home's abuse and neglect-zero tolerance policy under procedures only included procedures for suspected physical abuse and/or where a resident is at immediate risk. The policy referenced incidents of suspected abuse and neglect and did not include any alleged or witnessed incidents of abuse. The policy also referenced when sexual assault was suspected but had no reference to sexual abuse or any other interventions to manage when it was not sexual assault. The bottom of the policy referenced several other separate polices, including intimacy and sexuality and aggressive or violent behaviors, that were not a part of the zero tolerance of abuse policy. Under procedures in the intimacy and sexuality policy, for cognitively impaired residents, staff members that observed a sexual interaction between residents, were to immediately separate the residents involved and follow the procedures outlined in abuse and neglect-zero tolerance policy. The aggressive or violent behaviors (responsive behaviour policy) was not a part of the zero tolerance of abuse policy. Under the abuse and neglect-investigation policy, the procedure referenced a form for the full investigation that would be

developed by the Administrator in consultation with the Vice President but there was no investigation form included in the policy.

The Administrator was unaware where in the legislation of the requirements to include alleged, suspected and witnessed incidents of abuse. The Administrator indicated the end of home's abuse policy referenced additional policies that were to be followed for additional directions when dealing with resident-to-resident sexual abuse or physical abuse. The Administrator was unaware that those policies directed staff back to the abuse policy and that the abuse policy itself was to contain those directions, as per the requirements.

Failing to ensure the zero tolerance of abuse and neglect of resident's policy contained all of the requirements under FLTCA, 2021, s. 25(2), can lead to inconsistent procedures from all staff on how to respond to all incidents of alleged, suspected and witnessed incidents of both resident to resident physical and sexual abuse.

Sources: Abuse and Neglect-Zero Tolerance, Abuse and Neglect-Investigation policy, Resident Intimacy and Sexuality policy, Aggressive or Violent Behaviors policy and interview of staff (Administrator). [111]

WRITTEN NOTIFICATION NOTICATION OF INCIDENTS

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s.97(1)(a)*

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of a witnessed incident of abuse of resident #014 that had resulted in a physical injury to the resident that could potentially be detrimental to the resident's health or well-being.

Rationale and Summary

Resident #014 had sustained an injury by resident #013, in a specified area. An RN confirmed the SDM was notified the day after the incident occurred when they discovered the SDM had not yet been notified.

Failing to immediately notify the resident's SDM of abuse may lead to a lack of transparency to the SDM.

Sources: CI, health record of resident #013 and #014 and interview of staff. [111]

WRITTEN NOTIFICATION NOTIFICATION OF INCIDENTS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.97(2)

The licensee has failed to ensure that resident #013, #014, #010 and #011 substitute decision-maker(s), if any, were notified of the results of the investigation, required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary

There was an alleged resident to resident abuse incident involving resident #011 towards resident #010. There was no evidence the SDMs of either resident were notified of the results of the investigation upon completion.

There was a second witnessed incident of resident to resident abuse by resident #011 towards resident #010. There was no evidence the SDMs of either resident were notified of the results of the investigation upon completion. The Administrator was to notify the resident and/or their substitute Decision Maker of the results of the investigation immediately upon the completion of the investigation, as per the home's abuse policy. The Administrator indicated no awareness that the SDMs were to be made aware of the outcome of the investigation upon completion.

There was a witnessed incident of resident to resident abuse by resident #013 towards resident #014. There was no evidence the SDMs of either resident were notified of the results of the investigation upon completion.

Failing to notify the SDMs of the results of the home's investigations may lead to a lack of trust.

Sources: three CI's, health record of resident #013, #014, #010 and #011, home's investigations, Abuse and Neglect -Investigation policy and interview of staff. [111]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s.24(1)2*

The licensee has failed to ensure a person who has reasonable grounds to suspect abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident occurred immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A report to the Director was received regarding a witnessed resident to resident abuse incident involving resident #013 and #014. An afterhours report was received from an RN regarding the incident, the day after the incident occurred. The DOC indicated they submitted the report to

the Director but that an afterhours call was made the day of the incident. They were unaware that the afterhours call was not made until the day after the incident.

Failing to immediately report abuse of a resident to the Director may lead to abuse incidents not being immediately investigated.

Sources: CI, resident #013 and #104 health record, the home's investigation and interview of staff. [111]

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.