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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 5, 2023

Inspection Number: 2023-1387-0004

Inspection Type:
Proactive Compliance Inspection

Licensee: Centennial Place Millbrook Inc.

Long Term Care Home and City: Centennial Place Long-Term Care Home, Millbrook

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2024.01.02 12:23:18 -05'00'

Additional Inspector(s)
Lynda Brown (111)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30-31, and November 1-3, 6, 2023.

The following intake(s) were inspected:

- Intake #00100228 - Proactive Compliance Inspection (PCI) Intake

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was offered a specific meal beverage as set out in their plan of care.

Rationale and Summary

Observation of the resident's meal service indicated that they were not offered the specified meal beverage. On another date, during observations, the resident was not offered the specific meal beverage until staff was prompted by the Inspector.

According to the resident's plan of care they should have been offered the specific meal beverage at a specified frequency.

On November 1, 2023, the Registered Dietitian indicated that they had reviewed all residents with a specific diet and, in consultation with the Director of Care (DOC), added a task list documentation for specific diet items to ensure residents were offered the items and for auditing purposes.

There was risk identified when a resident was not offered a specific meal beverage as set out in their plan of care.

Sources: Observation of meal service, plan of care, interviews with relevant staff members. [704759]

Date Remedy Implemented: November 1, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee failed to ensure that every window in the home that opens to the outdoors and was accessible to residents.

Rationale and Summary

During the initial tour of the home, both Inspectors observed in a number of resident rooms had crank style windows. None of the windows had the crank mechanism present to allow for opening of the window. Observation throughout the home revealed none of the resident windows had the crank mechanism available to allow the residents access to open their windows.

Interview with the Environmental Services Manager (ESM) and the Administrator both indicated the cranks had been removed a number of years ago by the previous Administration's direction. The Administrator indicated the cranks would all be reapplied.

Failure to ensure that the residents windows are accessible to be opened negatively impacts the residents' comfort.

Remedied on November 2, 2023.

Sources: observations and interview of ESM and the Administrator. [111]

Date Remedy Implemented: November 2, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure the plan of care for a resident was based on the assessed needs of the resident.

Rationale and Summary

The plan of care for the resident indicated the resident required specific interventions for personal care, but did not indicate other specific care needs.

Observation of the resident indicated the resident was well groomed. The resident was confined to a wheelchair and required total staff assistance with feeding.

Interview with a Personal Support Worker (PSW) confirmed they had provided care to the resident but that they did not usually work on the unit. The PSW indicated they would refer to the resident's plan of care for the resident's care needs. The PSW indicated the resident required specific care needs and interventions that was not indicated on the plan of care.

Failing to ensure the plan of care for the resident was based on the residents

assessed needs leads to staff not being aware of the residents care requirements.

Sources: observation, health records and interview of staff. [111]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the plan of care was provided to a resident as indicated in the plan.

Rationale and Summary

During multiple observations of the resident on a specific date, the resident appeared unkempt. At a specific time, the resident's shirt was soiled, shoelaces untied, and they had a strong odour. The following day, the resident appeared well groomed, their hair appeared clean and they had no strong odour.

Interview with a PSW confirmed they had provided care to the resident on the specified date with a specific co-worker. They indicated the resident required total staff assistance to provide specific personal care. The PSW indicated the resident received a specific care at a specified frequency. They confirmed they had provided the specified care a number of hours earlier, and they had not yet provided the specified care to the resident since that time. They confirmed their shift was over in

a half hour and if they didn't have time they would pass on to the next shift. They indicated the resident received another specific care according to a specific list and was not scheduled for the specific care that day. They had no awareness of when the resident was scheduled for the specified care but was to receive the care at a specific frequency.

Interview with the DOC indicated the expectation was that residents were to be provided with the care according to the plan of care and they expressed concern that the resident had not been provided appropriate care.

Review of the plan of care for the resident indicated that a specified type of staff were not to provide care to the resident. The resident required assistance of two specified staff for specific personal care. The residents clothing and footwear was to be clean and appropriate. The resident had a preference for care provided. The specific list indicated the resident was to receive specific care at a different specific frequency.

Failure to provide care to the resident as indicated in their plan resulted in the resident having poor grooming, soiled clothing, care provided by the assistance of a specific type of caregiver and a strong odour.

Sources: observation of the resident, health records 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: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

On a specific date, a resident reported alleged incidents of neglect by staff during a visit by the Inspector. The information was received by the home on the same day. A review of the resident's clinical record indicated that there was no documentation that the resident had been assessed or provided emotional support.

The home's Abuse and Neglect – Zero Tolerance Policy indicated that registered staff was responsible to conduct assessments, provide emotional support for the alleged victim and document the findings. The Administrator indicated that the documentation was expected to be completed in the resident's clinical notes but that was not done.

There was minimal risk of harm to the resident when documentation requirements were not met.

Sources: Abuse and Neglect – Zero Tolerance Policy, clinical record, interviews with the resident, Administrator and other staff. [704759]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report a suspicion of neglect of a resident.

Rationale and Summary

On a specific date, a resident reported alleged incidents of neglect by staff during a visit by the Inspector. The information was received by the DOC on the same day. The Administrator indicated that the home initiated an investigation into these matters.

A review of the critical incident reporting website showed that there was no report submitted by the home on the specified date. The Administrator acknowledged that allegation of neglect by staff have been immediately reported to the Director.

There was minimal risk of harm to the resident when reporting requirements were not met.

Sources: critical incident system, interview with the resident, DOC and

Administrator. [704759]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

Rationale and Summary

On a number of specific dates, Inspectors found the storage room on a resident home area unlocked. The room contained cleaning and disinfectant supplies, resident hygiene products and a sharps container that contained used syringes. On the same dates, the storage room on another resident home area was also found unlocked. The room contained cleaning supplies and resident hygiene products.

During separates interviews with the Associate Director of Care (ADOC) and a PSW, they each confirmed the storage rooms were non-residential areas and were to be kept closed and locked when not in use.

Failure to ensure doors leading to non-residential areas were kept closed and locked places residents at risk for safety.

Sources: observations and interview of staff. [111]

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home's resident-staff communication and response system was easily accessed by a resident at all times.

Rationale and Summary

During the initial tour of the home, Inspectors observed that a resident was sleeping in their bed. Their bedside call bell was noted behind the resident's side table and not accessible. An Inspector located the button for the call bell under the resident's bed.

Interview with a PSW confirmed the call bell for the resident was stuck under the wheel of the bed and had to lift the resident's bed in order to free the call bell. They confirmed the resident would not have been able to access the call bell as a result.

Failing to ensure that the resident-staff communication and response system was

easily accessible to the resident places the resident at risk for not being able to call for staff assistance.

Sources: observations of the resident's room, and interview with a PSW. [111]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), or any other person specified by the resident, was notified within twelve hours upon the licensee being made aware of an alleged incident of neglect.

Rationale and Summary

On a specific date, the home was made aware of the resident's report of alleged incidents of neglect by staff. A review of the resident's clinical record indicated that the resident's emergency contact included their family member, and they were not notified of the alleged incident of neglect. Clinical record showed that their family member received notification previously from the home related to other specified incidents and care related concerns.

Interview with the resident indicated that they had not expressed to the home that

their family member was not to be contacted. DOC indicated that at the time of the home's investigation, the resident's family member was not notified because they were not listed as Power of Attorney nor SDM.

There was minimal risk of harm to the resident when notification requirements were not met.

Sources: clinical record, interviews with the resident and DOC. [704759]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with O. Reg. 246/22, s. 102(2)(b).

Specifically, the licensee shall:
1. Review and revise the home's policy Cleaning of Non-Critical Resident Equipment to include the labelling and proper storage of wash basins and raised toilet seats, especially in a shared resident washroom. Provide a copy of the revised policy to

the Inspector immediately upon request.

2. Re-train a housekeeper on the four moments of Hand Hygiene and the proper use of PPE, specifically gloves. Keep a documented record of the retraining records and provide a copy of retraining record to the Inspector immediately upon request.

3. Complete daily audits for one week on a resident home area unit, that includes the dates and times the audits were completed and by whom, to ensure housekeeping staff are following proper hand hygiene practices and appropriate use of PPE, specifically gloves. Keep a documented record of the audits completed and provide a copy of audits to the Inspector immediately upon request.

4. Conduct random weekly meal observation at two specific resident home areas for direct care staff assisting two residents with meal to ensure compliance with the home's hand hygiene program for a period of one month following the service of this order. Maintain a record of the observation, including the date, who conducted the observation, name of the staff observed, and actions taken in response to the audit findings and provide the record to the Inspector immediately upon request.

Grounds
The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with regarding labelling and storing of non-critical resident equipment.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 5.5, directs, the licensee shall identify how IPAC policies and procedures will be implemented in the home.

Rationale and Summary

1. The licensee policy, Cleaning of Non-Critical Resident Equipment, states under resident basins, on a daily basis, or as needed, these items are collected from resident's rooms and taken to the soiled utility room. Once clean and dry, items are returned to the clean utility room to be stored until needed. If a resident uses a specific item on a regular basis, once clean an item can be returned to that resident's room. The policy did not specify whether the items were to be labelled when in a shared resident bathroom and where they were to be stored in the resident's room. The policy did not indicate they were to be labeled or that they were not to be stored on the floor.

During the initial tour of the long-term care home (LTCH) and subsequent observations the following was observed:
-Specific resident room (washroom): three wash basins were observed sitting on the floor under the sink, unlabeled. This is a shared resident washroom.
-Specific resident room (washroom): one wash basin was sitting on the floor under the sink, unlabeled. This is a shared resident washroom.
-Specific resident room (washroom): one raised toilet seat and one wash basin sitting the floor, unlabeled. This is a shared resident washroom.

Interview with the IPAC Lead confirmed that personal care items, including wash basins and raised toilet seats, were to be individually labelled for resident use in a shared washroom. They also indicated the wash basins were to be stored in the individual resident's cupboard and not stored on the floor.

Unlabeled and improperly stored personal care items, specifically wash basin's, and raised toilet seats in washroom, places residents at risk for infections, especially in shared spaces.

Sources: observations in the home, and interview with the IPAC Lead. [111]

2. The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with regarding hand hygiene practices.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

During the initial tour of the LTCH on a resident home area, housekeeper (HSK) was observed cleaning handrails in the hallway wearing one glove on their right hand. The HSK then entered a resident room and cleaned their room, without performing hand hygiene prior to entering their room. The HSK exited the resident's room without performing hand hygiene and then entered another resident room to clean the resident's room, again without performing hand hygiene.

During an interview with the IPAC Lead, they confirmed the expectation for all housekeeping staff is to perform hand hygiene prior to entering/exiting a resident rooms and in between housekeeping tasks.

Failure to complete hand hygiene at the four moments of hand hygiene places

residents at risk of harm due to transmission of infections.

Sources: observations in the home, and interview with the IPAC Lead. [111]

3. The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control were complied with regarding hand hygiene practices.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary

During the initial tour of the LTCH on a resident home area, an HSK was observed cleaning handrails in the hallway wearing one glove on their right hand. The HSK then entered a resident room and cleaned their room, without doffing their glove prior to entering their room. The HSK exited the resident's room without doffing the same glove and then entered another resident room to clean the resident's room, again without doffing the glove.

During an interview with the IPAC Lead, they confirmed the expectation for all housekeeping staff is to don and doff gloves prior to entering/exiting a resident rooms and in between housekeeping tasks.

Failure to follow the proper use of PPE, specifically glove use, places residents at risk of harm due to transmission of infections.

Sources: observations in the home, and interview with the IPAC Lead. [111]

4.The licensee has failed to ensure to implement a standard issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that Routine Practices in the IPAC program were followed by three staff members in accordance with the Infection Prevention and Control Standard for Long Term Care Homes. Specifically, Routine Practices shall include hand hygiene, and are followed in the program as is required by Additional Requirement 9.1 b) Routine Practices under the IPAC Standard.

Rationale and Summary

Observation of a meal service at a resident home area indicated that a PSW did not wash their hands between assisting two residents with meal while seated between the two. Observation of meal service at another resident home area indicated that another PSW did not wash their hands between assisting two residents with meal while seated between the two.

A PSW indicated that they did not perform hand hygiene between assisting two residents with meal. The second PSW indicated that they performed hand hygiene after assisting with meal but not between assisting two residents with meal.

According to the home's hand hygiene program, effective and safe hand hygiene practices protect the staff and residents from infections. Practices included handwashing with and Alcohol Based Hand Rub or soap and water. Staff must wash their hands immediately before and after performing any task involving resident contact.

There was risk of infection transmission identified when two staff members did not wash their hands while providing meal assistance between residents.

Sources: the home's policy titled Hand Hygiene Program, observations of meal services, interviews with staff. [704759]

This order must be complied with by January 26, 2024

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.