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
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Original Public Report

Report Issue Date: September 17, 2024	
Inspection Number: 2024-1387-0003	
Inspection Type: Critical Incident Follow up	
Licensee: Centennial Place Millbrook Inc.	
Long Term Care Home and City: Centennial Place Long-Term Care Home, Millbrook	
Lead Inspector The Inspector	**Inspector Digital Signature** Elizabeth C Montoya Digitally signed by Elizabeth C Montoya Date: 2024.09.25 17:09:56 -04'00'
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 4-6, 9-13, 2024.

The following intake(s) were inspected:

- Two intakes related to alleged physical abuse of a resident.
- One intake related to an outbreak.
- One intake related to a fall of a resident that resulted in injury.
- One intake for Follow-up #: 1 -CO #001, O. Reg. 246/22 - s. 40, CDD: June 1, 2024
- One intake for Follow-up #: 1 -CO #002, FLTCA, 2021 - s. 24 (1), CDD: June 1, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1387-0001 related to O. Reg. 246/22, s. 40 inspected by the Inspector. Order #002 from Inspection #2024-1387-0001 related to FLTCA, 2021, s. 24 (1) inspected by the Inspector.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that any standard or protocol issued by the

Director with respect to the Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee has failed to ensure that staff performed hand hygiene at the moments required.

Rationale and Summary
According to 9.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included 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).

During this inspection, two staff members were observed assisting multiple residents into the dining room and applying clothing protectors to them. Staff did not perform hand hygiene between resident interactions.

The Registered Nurse (RN) and the Infection Prevention and Control (IPAC) lead confirmed that all staff were required to perform hand hygiene between residents.

The staff's failure to perform hand hygiene between residents placed residents at risk of contracting infectious diseases.

Sources: Observations, interviews with the PSW and the IPAC lead.