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

Public Report

Report Issue Date: February 19, 2025

Inspection Number: 2025-1387-0002

Inspection Type:
Critical Incident

Licensee: Centennial Place Millbrook Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10-12, 14, 18-19, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

Intake: #00134735 - Enteric - Outbreak.
Intake: #00137078 -Physical abuse of resident by resident.
Intake: #00138520 -Physical abuse altercation between residents..
Intake: #00138732 - Sexual abuse of resident a by resident.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident plan of care indicated specific interventions when approaching the resident to provide care . An incident occurred when the PSW failed to follow the plan of care when resident refused care. This interaction caused increased agitation for the resident resulting in a responsive behavior. During an interview with the Behavior Supports Coordinator (BSC) they acknowledged PSW should have followed the plan of care when interacting with resident.

Sources: Clinical records for resident, CIR and interview with BSC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 resident-to-resident emotional abuse incident that occurred in January 2025, a Critical Incident Report (CIR) was submitted one day late. The Director of Care (DOC) confirmed during an interview, staff should have reported this immediately to the Director.

Sources: Critical Incident Report (CIR), Abuse and Neglect -Zero Tolerance Policy , Interview with DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director was complied with when doffing Personal Protective Equipment (PPE).

In accordance with Additional Requirement 9.1 (d) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure proper use of PPE, including removal of PPE was completed in the correct sequence. INSP observed PSW incorrectly removed the isolation gown and doff in the correct sequence after providing care to a resident positive with COVID-19, that required additional precautions.

Sources: Observations, Line Listing for Outbreak.