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: April 29, 2025
Inspection Number: 2025-1387-0003
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): April 14 - 17, and April 22-24, 2025.
The inspection occurred offsite on the following date(s): April 25, 28, 2025.

The following intake(s) were inspected:

Intake #00139078, regarding a ARI COVID-19 Outbreak.
Intake #00141817, regarding sexual abuse of a resident by a resident.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Communication and response system

NC #001 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. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that a resident was able to access the call bell at all times. The resident's records and confirmation with the Behaviour Support Coordinator (BSC) and Assistant Director of Care (ADOC) confirmed, the resident was unable to access to their call bell to ring for staff assistance, when a co-resident entered their room and was exhibiting responsive behaviours towards them.

Sources: Critical Incident Report (CIR), a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between a resident and co-residents. The resident had a specialized interventions implemented after an incident of responsive behaviours towards a resident. After a period of time the specialized intervention was discontinued, two days later the resident had responsive behaviours towards a different resident. The BSC and Director of Care (DOC) confirmed no new interventions were documented in the residents plan of care to minimize the risk towards resident altercations.

Sources: Resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the program in regard to the Handling of Isolation Linen. A PSW was observed walking down the hallway with PPE on and soiled linen in their hands. The PSW and the ADOC confirmed the resident's soiled linen was to be put in the linen bags at the location the care was provided.

Sources: Policy-Handling of Isolation Linen, observation, interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to ensure that a suspected outbreak was reported to the Public Health Unit. In accordance O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that reporting protocols for outbreak management was complied with based on the Health Protection and Promotion Act. The home's outbreak management policy defined an outbreak. The policy directed the DOC or Infection Prevention and Control (IPAC) lead to notify the Public Health Unit of a suspected outbreak. The DOC indicated that they followed a guidance document which defined suspected outbreaks. The suspected outbreak was not reported to the Public Health Unit the same day when the two residents had respiratory symptoms and resided on the same unit. The IPAC lead and DOC confirmed Public Health was not called until the following day.

Sources: Public Health Unit, resident's clinical records, the home's policy-Confirming outbreak, Ontario Public Health Standards, moh-recommendations-for-outbreak-prevention-and-control-in-institutions, Signs and Symptoms of Infection document, interview with staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 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:

The IPAC lead or designate will provide in person education on donning Personal Protective Equipment (PPE) requirements for staff and residents on additional precautions. The staff education will include PSW staff working the day shift in two resident home areas on a identified date. Keep a documented record of the education provided, who provided the education, and the date the staff was educated.

Grounds

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.

1. In accordance with Additional Requirement, Routine Practices, 9.1 (d) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that staff and that staff assist a resident to apply and select the appropriate Personal Protective Equipment (PPE).

A resident had respiratory symptoms and was on additional precautions. The posted signage outside of the resident's door indicated the required PPE. The

resident was observed being transported down the hallway without a mask. A PSW was observed not wearing all the required PPE in the residents room and while transporting the resident down the hallway and within two meters of the resident. The PSW confirmed they did not apply all the PPE as required and reported they were not aware the resident required a mask when transporting them down the hallway. On the same day a PSW was observed entering the resident's room to deliver a drink and they did not apply the PPE as posted.

A separate resident residing on another home area had respiratory symptoms and signage was posted for additional precautions. The sign posted on the resident’s door indicated the required PPE to be applied. The PSW was observed entering the resident's room without all the required PPE. The PSW confirmed the missing PPE should have been donned when they provided direct care to the resident.

The ADOC confirmed that two of the PSW's should have worn the required PPE as directed on the posted signs and the PSW dropping off the drink to the resident should have worn a mask when entering the resident's room.

When staff did not select and apply the required PPE for two residents on additional precautions for respiratory symptoms there was a increased risk of transmission, which may lead to an respiratory outbreak impacting the residents health living at the home.

Sources: Policy's for Infection Prevention and Control, Routine Practices and Additional Precautions In All Health Care Settings, observation's of staff, residents clinical records, interviews with staff.

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.

2. In accordance with Additional Precautions, 9.1(e), under the IPAC standard for

Long-Term Care Homes (April 22, 2022, revised September 2023), the licensee has failed to ensure that at minimum, Additional Precautions include the correct Point-of-care signage was posted related to contact precaution was not posted as part of the signage indicating that enhanced IPAC control measures were in place for a resident.

The resident's clinical records indicated the resident had respiratory symptoms and was on additional precautions, a sign was posted on the residents door. Observation of the resident's additional precaution sign and confirmation from the ADOC indicated the incorrect signage was posted and different additional precaution sign was required.

Sources: Policy- Infection Prevention and Control, observation, residents clinical records, Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Setting, PIDAC Routine Practices and Additional Precautions in All Health Care Settings, interview with staff.

This order must be complied with by June 27, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Prior non-compliance with O. Reg 246/22, s. 102 (2) (b) included:
-WN issued in inspection #2025-1387-0002, issued February 19, 2025.
-WN issued in inspection #2024-1387-0003, issued September 18, 2024.
-WN issued in inspection #2024-1387-0002, issued July 31, 2024.
-WN issued in inspection 2024-1387-0001, issued March 25, 2024.
-CO issued in inspection #2023-1387-0004, issued December 5, 2023.
-WN issued in inspection #2023-1387-0002, issued May 18, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.