

**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:** July 16, 2025

**Inspection Number:** 2025-1387-0004

**Inspection Type:**

Critical Incident  
Follow up

**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): July 7, 8, 9, 10, 11, 14, 15, 16, 2025

The following intake(s) were inspected:

- Intake: #00144900 - CIR related to physical abuse of resident by resident.
- Intake: #00145526 - CIR related to a fall incident of a resident.
- Intake: #00145542 - CIR related to physical abuse and an altercation between residents.
- Intake: #00146266 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) CDD June 27, 2025
- Intake: #00146483 - CIR related to a fall incident of a resident.
- Intake: #00147886 - CIR related to physical abuse of resident by resident.

**Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1387-0003 related to O. Reg. 246/22, s. 102 (2)

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(b)

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: Plan of Care

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 was provided to a resident, as specified in the plan, when, on a specified time and date, a fall prevention intervention device was not in place for the resident. The Falls Committee Co-Chair confirmed that the falls prevention intervention should have been applied to the resident.

**Sources:** observation and clinical records of a resident, staff interviews with PSW staff and Falls Committee Co-Chair.

### WRITTEN NOTIFICATION: Duty to protect

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

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from abuse by a co-resident.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Clinical records of both residents involved indicated that on two identified dates, a resident sustained physical injuries caused by a co-resident. Registered Nurse (RN) and Registered Practical Nurse (RPN) agreed that the initial incident fits the definition of physical abuse toward the resident. The RPN indicated that the co-resident was apologetic for the second incident and did not mean to hurt the resident.

**Sources:** Critical Incident Reports (CIR), residents' clinical records, and Interviews with RN and RPN.

## **WRITTEN NOTIFICATION: Pain management**

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

**Non-compliance with: O. Reg. 246/22, s. 57 (2)**

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically

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appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident sustained a fall on a specified date and time. The resident's pain was assessed at low level on the PAINAD scale. As needed pain medication was administered to the resident with good effect. On the following day, the resident complained of increased pain.. The documentation indicated that the resident had increased pain and was crying in pain with care. When the resident's pain increased, the resident was not assessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose.

**Sources:** Critical Incident Report, resident's clinical records, Pain Assessment Protocol Policy Number: RS-D-43 and interview with an RN.

## **WRITTEN NOTIFICATION: Altercations and Other Interactions**

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

**Non-compliance with: O. Reg. 246/22, s. 59 (b)**

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, when a physical altercation

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occurred between two residents. The resident was attacked by a co-resident, causing both residents to fall. PSW staff members were present and could not separate the two residents. The care plans directed staff to ensure that both residents were not to be in the immediate vicinity, and the Behavioural Supports Coordinator (BSC) acknowledged that at the time of the altercation, the two residents were in the immediate vicinity of each other.

**Sources:** Critical Incident Report, residents' clinical records, staff interviews.

## **WRITTEN NOTIFICATION: Administration of drugs**

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

### **Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that a resident received as needed pain medication in accordance with the directions for use specified by the prescriber.

A resident sustained a fall on a specified date and time. The resident's pain was assessed at a low level on the PAINAD scale. As needed pain medication was administered to the resident with good effect. The documentation indicated that on the following day, the resident had increased pain and was crying in pain with care. The resident's Medication Administration Record indicated three physician's orders to administer as needed pain medication. No pain medication was administered to the resident when the resident had increased pain during care. Registered Nurse (RN) indicated that as needed pain medication should have been administered when the resident complained of increased pain.

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**Sources:** Critical Incident Report, resident's clinical records and interview with RN.

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**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

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