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: January 13, 2026
Inspection Number: 2025-1387-0006
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): December 29-31, 2025 and January 2, 6-9, 12-13, 2026.

The inspection occurred offsite on the following date(s): January 5, 2026.

The following intake(s) were inspected:
• Intakes #00160253, #00163501, #00163657, and #00164973 - resident incidents resulting in injury.

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

Falls Prevention and Management

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.

1.A resident was identified as being at risk, related to their safety. Documentation identified the resident was assessed specific to their care needs and need for a mobility aid. The resident was involved in an incident and sustained injury. Documentation identified that at the time of the incident the care needs of the resident had not been provided as planned.

Sources: clinical health record for the resident, Critical Incident; and an interview with the resident.

2.A resident was identified as being at risk, related to their safety. Documentation identified strategies to prevent incidents and reduce injury had been developed. Documentation identified the resident was involved with an incident and sustained injury. Documentation identified that at the time of the incident the care strategies for the resident had not been provided as planned.

Sources: clinical health record for the resident, Risk Management, and a Critical Incident.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A care strategy to support safety was added to the care plan for a resident. The intervention was not included as a task in electronic care records for the resident. Paper documents provided by the home for the identified care strategy showed incomplete documentation. A staff member confirmed that the identified care strategy should have been added as a task in the electronic resident records.

Sources: clinical records for the resident; and an interview with staff.

WRITTEN NOTIFICATION: When reassessment, revision is

required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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 care plan for a resident was not revised when the resident's care needs changed and the resident required an identified mobility aid for mobility.

Sources: clinical records for the resident; and interviews staff and support staff.

WRITTEN NOTIFICATION: Reassessment, revision

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

A resident was assessed as being at risk, related to their safety. Interventions were identified in the plan of care. Documentation identified the resident had prior incidents. On an identified date the resident was involved with an incident and sustained injury resulting in transfer to an acute care facility. The plan of care for the resident failed to identify different approaches were considered to prevent further incidents and mitigate risk to the resident.

Sources: clinical health record for the resident, Risk Management; and an interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning

techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident was involved with an incident and sustained injury.
A registered staff member indicated that staff had inappropriately transferred the resident following the incident.

Sources: clinical health record for the resident, licensees video surveillance footage, licensee policy; and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with.

The licensee policies related to falls prevention and management directed that staff are to immediately notify the physician of a specific injury to a resident.

A resident was involved with an incident and sustained injury. Documentation failed to identify that the physician was immediately notified of the incident and related injury.

Sources: clinical health record for the resident, licensee policy; and an interview with a manager.

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