**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

# Original Public Report

| **Report Issue Date: July 13, 2023** | |
|---|---|
| **Inspection Number:** 2023-1387-0003 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Centennial Place Millbrook Inc. | |
| **Long Term Care Home and City:** Centennial Place Long-Term Care Home, Millbrook | |
| **Lead Inspector**<br>Catherine Ochnik (704957) | **Inspector Digital Signature** |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20 - 23, 26, 27 and 29, 2023

The following intakes were inspected:

- Intake: #00001602 - related to a complaint regarding improper care and neglect
- Intake: #00006801 and intake: #0008694 - were related to responsive behaviours

The following intakes were completed in this inspection:

- Intake #00006245 - related to improper care
- Intake: #0003070, intake: #00021131, intake #00087149, intake #00087759, and intake #00088337 - were related to responsive behaviours

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

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 (4) (b)

**Summary and Rationale**

The Ministry of Long-Term Care (MLTC) received a complaint related to an allegation of improper care and neglect of resident #005 regarding the treatment of a suspected health concern.

The associated Critical Incident Report (CIR) indicated that the resident informed their Power of Attorney (POA) that they experienced symptoms of a health concern. Resident #005’s POA reported this to Registered Practical Nurse (RPN) #108 on the same day.

The home’s investigation notes revealed that RPN #108 did not document the concern from the POA on the same day. The home’s Facility Supervisor 24-hour Report records indicated that concerns around resident #005 experiencing symptoms of a health concern were not documented until two days later.

Resident #005’s progress notes revealed that RPN #113 documented that they would follow up with the physician regarding the resident’s health concern. Documentation of a physician fax transmittal showed that a fax was sent to the physician by RPN #108 nine days after the POA brought the health concern forward.

RPN #108 confirmed that they did not inform the physician about the suspected health concern for resident #005 until nine days after the POA brought the health concern forward.

The Director of Care (DOC) acknowledged that staff failed to collaborate with the unit Registered Nurse (RN) Supervisor and physician to ensure that the resident received treatment for the suspected health concern in a timely manner. The DOC also confirmed that the home’s Shift to Shift Communication policy and Documentation in Health Record policy was not followed.

There was moderate risk to the safety and well-being of the resident when they did not receive the required treatment for a suspected health concern in a timely manner.

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**Sources:** CIR, resident #005's clinical records, the home's investigation notes, shift report records, the home's policies: Documentation in the Health Record and Shift to Shift Communication, interviews with staff.

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## WRITTEN NOTIFICATION: Duty to Protect

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

**Summary and Rationale**

The Ministry of Long-Term Care (MLTC) received a complaint related to an allegation of improper care and neglect of resident #005 regarding the treatment of a suspected health concern.

The associated Critical Incident Report (CIR) indicated that the resident informed their POA that they experienced symptoms of a health concern. The POA reported this to the Charge Nurse on the same day. A medication order to treat a suspected health concern was received by the physician nine day later, at which point resident #005 was experiencing worsening symptoms.

Resident #005's progress notes indicated the resident was experiencing symptoms of a health concern two days after the initial concern was brought forward by the resident's POA. Several days later, RPN #113 documented they would follow up with the physician, however the physician was not notified at this time.

The home's investigation notes revealed that staff did not communicate resident #005's suspected health concern to the physician in a timely manner.

RPN #108 acknowledged that they did not inform the physician about the suspected health concern for resident #005 until nine days after the POA brought the health concern forward.

The Director of Care (DOC) acknowledged that staff failed to collaborate with the unit Registered Nurse (RN) Supervisor and physician to ensure that the resident received treatment for the suspected health concern in a timely manner. The DOC also confirmed that the home's Shift to Shift Communication policy and Documentation in Health Record policy was not followed.

There was moderate risk to the safety and well-being of the resident when they did not receive the required treatment for a suspected health concern in a timely manner.

**Sources:** CIR, resident #005’s clinical records, the home’s investigation notes, the home’s policies: Documentation in the Health Record and Shift to Shift Communication, interviews with staff.

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