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

Original Public Report

Report Issue Date: July 31, 2024.
Inspection Number: 2024-1387-0002
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): July 23, 24, 25, 2024.

The following intake(s) were inspected:
A Critical Incident related to a fall of a resident that resulted in injury.

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: HOME TO BE SAFE, SECURE ENVIRONMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

During a tour of the home, Inspector observed in an unsupervised Activity Room, a staff member's personal belongings located on the top of office desk. Furthermore, Inspector observed that the Activity Room's cabinet doors were unlocked and easily accessible, which contained, an unlocked microwave, numerous large bottles of paint, shaving cream bottle, numerous nail polishes, nail polish remover bottle, and curling irons.

During a tour of the home, Inspector observed in an unsupervised Resident Dining Room, a small, enclosed room with opened and unlocked doors, with easy access to an unlocked microwave.

The Inspector observed in a second unsupervised Activity Room, that the Activity Room's cabinet doors were unlocked and easily accessible, which contained, an unlocked microwave, toaster, grill, kettle, numerous glue bottles, numerous nail polishes, nail polish remover bottle, a heated nail polish dryer equipment, numerous large bottles of paint, and multiple paint brushes soaking in a cup of unknown green liquid solution.

The Inspector observed a third unsupervised Activity Room, scissors located on the top of office desk. Furthermore, Inspector observed that the Activity Room's cabinet doors were unlocked and easily accessible, which contained, numerous bottles of

paint, numerous nail polishes, nail polish remover bottle, shaving cream bottle, numerous bottles of glue, office tools, container of cashews, chocolate, and a container with unknown light brown substance inside indicated as P.B. April 2. Additionally, Inspector observed in the under sink cabinet, two bottles of Diversey Oxivir Plus (Disinfectant Cleaner Concentrate), a bottle of Diversey Oxivir Tb (Surface Cleaner and Intermediate Level Disinfectant, General Virucide, Tuberculocide), and a bottle of Diversey Suma Detergent Sanitizer.

The Director of Resident and Family Services confirmed that the home's Activity Room cabinets, which contained any substances/objects that were potentially toxic or could pose a safety risk to residents, were to be locked at all times when the room was unsupervised.

Failure to ensure a safe and secure environment for the residents, specifically by not locking substances and/or objects that were potentially toxic or could pose a safety risk to residents, has placed residents' safety and well-being at increased risk.

Sources: Inspector Observations, and an Interview with Staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 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 (IPAC). O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure to implement any standard or protocol issued by the Director with respect to IPAC. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that Additional Screening Requirements were followed in the home in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Screening Requirement 11.6 under the IPAC Standard, directs that the licensee shall ensure signage is posted at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Rationale and Summary

During entry to the home, Inspector observed that the home did not have the Required Additional Screening (RAS) signage posted at the front entrance that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Upon entering into the home's lobby, Inspector observed, near the front reception desk, located at the visitor sign-in book, that the home did have the RAS signage posted, however, it was not easily visualized.

During tour of the home, Inspector did not observe the RAS signage posted throughout the home.

The IPAC Lead indicated that the RAS signage posted throughout the home was located in the staff lounge, washroom and on elevators. The IPAC Lead confirmed

that the home had signage posted at the front entrance and throughout the home listing the signs and symptoms of infectious diseases for self-monitoring, as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Further observations on the second floor, staff lounge and washroom did not have the RAS signage posted.

When the licensee failed to ensure that signage was posted at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual, this placed the residents and staff at increased risk for infection transmission.

Rationale and Summary

2) The licensee has failed to ensure that Additional Precautions were followed in the IPAC Program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Requirement 9.1 under the IPAC Standard, directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

At minimum, section 9.1 (f) for Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal of PPE.

Inspector observed, that two resident room's had PPE garbage bins located on the opposite side of the bedroom, and not directly at the inside of the bedroom door, for staff to dispose of used PPE and have immediate access to Alcohol Based Hand Rub (ABHR) upon exiting bedroom, in accordance with Best Practices.

Inspector observed a resident room that did not have any PPE garbage bin located within the room or directly at the inside of the bedroom door for staff to dispose of used PPE and have immediate access to ABHR upon exiting bedroom, in accordance with Best Practices. Furthermore, a Registered Practical Nurse (RPN) confirmed that the resident room did not have a PPE garbage bin located within the room or directly at the inside of the bedroom door and that they would follow-up to retrieve one.

The IPAC Lead confirmed that an RPN had reported that a resident room did not have a PPE garbage bin to dispose of used PPE and that they had provided them with a PPE garbage bin. The IPAC Lead indicated that residents under additional precautions were to have garbage bins located directly at the inside of the bedroom door, for staff to dispose of used PPE and have immediate access to ABHR prior to exiting bedroom.

The licensee has failed to implement IPAC Standard, 9.1, specifically related to the disposal of used PPE, has placed the residents and staff at increased risk for infection transmission.

Sources: Tour Observations, IPAC Lead Resident List, and Interviews with Staff.

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief

Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act are followed in the home, specifically ensuring that Alcohol Based Hand Rub (ABHR) was not expired.

As directed by: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings April 2024, stating that ABHR is not to be expired.

Rationale and Summary

During a tour or the home, multiple expired ABHR was observed throughout the home.

Inspector informed the IPAC Lead of expired ABHR throughout the home, and they confirmed that they would follow up and replace all expired ABHR. Furthermore, the IPAC Lead later confirmed that they had observed the expired ABHR throughout the home and have since replaced them and have disposed of all expired ABHR. The IPAC Lead confirmed that housekeeping was responsible for monitoring the expiry dates of ABHR, and they were responsible for ordering the homes ABHR supply.

Failure to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act are followed in the home, specifically ensuring that ABHR was not expired has increased the

potential for the spread of infection within the home.

Sources: Tour Observations and Interviews with Staff.

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