Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date June 9, 2022
Inspection Number 2022_1463_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Millcreek Care Centre

Long-Term Care Home and City
Millcreek Care Centre
286 Hurst Drive
Barrie, Ontario
L4N 0Z3

Lead Inspector
Jennifer Nicholls #691

Inspector Digital Signature
Jennifer J Nicholls
2022.06.23 14:44:36 -04'00'

Additional Inspector(s)
Amanda Belanger #736
Inspector #741724 Basel Mansour was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30, 2022 -June 3, 2022.

The following intake(s) were inspected:
- Two logs related to improper care of a resident.
- Two complaint logs related to an elopement of a resident and improper care of a resident.
- Three logs related to missing narcotics.

The following **Inspection Protocols** were used during this inspection:
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

During the course of this inspection, the inspector (s) made relevant observations, reviewed records, and conducted interviews, as applicable.

WRITTEN NOTIFICATION: PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (7)
The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident.

Rationale and Summary
A resident sustained a fall with significant injury after the staff member did not follow the plan of care for a resident.

Sources: The resident's care plan and progress notes; Critical Incident (CI), internal investigation notes, and staff files; interviews with a Personal Support Worker (PSW), and other relevant staff. [736]

WRITTEN NOTIFICATION: DOORS IN THE HOME

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.12 (3)
The licensee has failed to ensure a door leading to a non-residential area was kept closed and locked when not supervised by staff.

Rationale and Summary
During the inspection, the Inspector noted that the door leading to a stairwell, that residents should not have had access to, did not re-lock after being unlocked without significant force being applied to the door. The Executive Director (ED) indicated that a screw had been preventing the door from re-locking after being opened.

Sources: Inspector observations; complaint log and internal complaint record; interview with ED, and other staff. [736]

WRITTEN NOTIFICATION: REPORTING

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 1
The licensee has failed to ensure that an allegation of improper care of a resident was immediately reported to the Director.

Rationale and Summary

An allegation of improper care related of a resident was not reported to the Director immediately, as required. The Director of Care (DOC) confirmed that the allegation of improper care was not reported immediately to the Director and should have been.

Sources: Critical Incident (CI); a resident's progress notes; internal investigation notes; licensee policy "Critical Incidents; Index ID E-45", last reviewed February 2022; interview with DOC. [736]

WRITTEN NOTIFICATION: NUTRITION

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 73 (1) 10.
The licensee has failed to ensure that resident was positioned safety, and proper techniques were used to assist the resident, with their meal.

Rationale and Summary
A resident was being fed by a staff member, when it was noted that the resident was not positioned appropriately to be assisted with their meal, and was coughing. The DOC indicated that the resident should have been positioned in a different way to promote safe eating, prior to being fed.

Sources: A resident's progress notes, and care plan; Critical Incident (CI); interview with DOC, and other relevant staff. [736]