

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: August 27, 2025

Inspection Number: 2025-1463-0006

Inspection Type:

Critical Incident

Licensee: Mill Creek Care Centre

Long Term Care Home and City: Mill Creek Care Centre, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 11-14, 18-20, 22, 25-27, 2025

The following intake(s) were inspected:

- Intake #00149125, CI #2981-000042-25 - related to a fall which resulted in injury.
- Intake #00149872, CI #2981-000046-25 - related to an injury of unknown cause.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

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Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

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.

A resident required a specific intervention to be in place and it was not. On a subsequent observation, it was in place.

Sources: Observations of a resident; Interviews with staff.

Date Remedy Implemented: August 26, 2025

WRITTEN NOTIFICATION: Emergency plans

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

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the

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following:

1. Dealing with emergencies, including, without being limited to,
 - vi. medical emergencies,

The licensee failed to ensure the homes emergency plan for transferring residents to hospital was followed. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for medical emergencies were complied with. Specifically, the home's transfer to hospital policy indicated that if a nursing assessment indicated an emergency medical intervention was required, the nurse manager/in-charge could make the decision to transfer a resident to hospital.

A resident's transfer to hospital was delayed.

Sources: Review of a resident's clinical records; Transfer to Hospital Policy; Interviews with staff.