

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

<b>Report Issue Date:</b> December 19, 2025
<b>Inspection Number:</b> 2025-1463-0008
<b>Inspection Type:</b> Complaint Critical Incident
<b>Licensee:</b> Mill Creek Care Centre
<b>Long Term Care Home and City:</b> Mill Creek Care Centre, Barrie

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 9, 10, 15 - 19, 2025

The inspection occurred offsite on the following date(s): December 11, 12, 2025

The following intake(s) were inspected:

- Intake: #00157807: related to the prevention of abuse and neglect.
- Intakes: #00159924 and #00159924: complaints related to falls management.
- Intake: #00162517: complaint regarding multiple care concerns.
- Intake: #00163089: related to medication management.

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

- Skin and Wound Prevention and Management
- Food, Nutrition and Hydration
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## INSPECTION RESULTS

**WRITTEN NOTIFICATION: Reporting certain matters to the Director**

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

**Non-compliance with: FLTCA, 2021, s. 28 (1) 1.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Staff were informed of an alleged incident of improper care of a resident, and also stated that this incident was reported to management.

This incident was not reported to the Director.

**Sources:** Interviews with staff and a substitute decision maker.

## **WRITTEN NOTIFICATION: Required programs**

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

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.**

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:

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The home's skin and wound interdisciplinary team policy indicated that for bruises:

- Complete altered skin integrity assessment,
- Complete the Investigation Guide to identify the origin and contributing factors.

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Staff did not follow the home's skin and wound policy when they did not complete the required Investigation guide or the required assessment when a resident sustained a bruise.

**Sources:** Interview with staff, a resident clinical records.

### **WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,
  - ii. names of any staff members or other persons who were present at or discovered the incident, and

The Critical Incident report did not include the name of the staff member that was present at the incident of a reported alleged abuse.

**Sources:** Critical Incident Report, interview with Director of Care.

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## WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. v.**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

3. Actions taken in response to the incident, including,
  - v. the outcome or current status of the individual or individuals who were involved in the incident.

The Critical Incident report was not amended to include the outcome of the current status of the staff member who was involved in the incident of a reported alleged abuse.

**Sources:** Critical Incident Report, interview with Director of Care.

## WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)**

Medication management system

s. 123 (3) The written policies and protocols must be,

- (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A medication reconciliation was completed for a resident without following the home's Medication Reconciliation Policy. This resulted in a medication incident.

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**Sources:** Hospital discharge summary, Medication Reconciliation, Medication Reconciliation Policy, Homes Investigation notes, Interviews with staff.

## WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident received medications that had been discontinued. After receiving these medications, the resident demonstrated clinical decline and was transferred back to the hospital.

**Sources:** Resident's clinical records, Hospital Discharge Summary, Homes Investigation Notes, Medication Reconciliation, Interview with DOC.



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**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

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