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 West District
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Public Report

Report Issue Date: March 3, 2025

Inspection Number: 2025-1463-0002

Inspection Type:
Complaint
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): February 18-21, 24-27, 2025

The following intake(s) were inspected:

- Intake: #00132892 - [IL-0133952-AH / CI-2981-000101-24] - related to neglect of a resident
- Intake: #00133424 - [IL-0134128-AH / CI-2981-000106-24] - related to transferring techniques resulting in injury
- Intake: #00133420 - [IL-0134126-AH / CI-2981-000105-24] - related to improper care of a resident resulting in injury
- Intake: #00133615 - [CI-2981-000104-24] - related to a resident fall
- Intake: #00133893 - [IL-0134344-AH / CI-2981-000109-24] - related to improper care of a resident resulting in injury
- Intake: #00134184 - [IL-0134489-AH / CI-2981-000110-24] - related to improper care of a resident resulting in injury
- Intake: #00134461 - [CI-2981-000112-24] - related to neglect of a resident
- Intake: #00136583 - [IL-0135578-AH / CI-2981-000007-25] - breakdown of care equipment

- Intake: #00137089 - [IL-0135806-AH / CI-2981-000012-25] - related to concerns with meal assistance
- Intake: #00137090 - [IL-0135807-AH / CI-2981-000013-25] - related to concerns with resident care
- Intake: #00138177 - [IL-0136278-CW] - complaint related to resident care
- Intake: #00138293 - [IL-0136301-AH/ CI-2981-000020-25] - related to concerns with resident care
- Intake: #00139658 - [IL-0136818-CW] - complaint related to resident care

The following intakes were completed:

- Intake: #00133603 - [CI-2981-000103-24] - related to a resident fall
- Intake: #00134464 - [CI-2981-000113-24] - related to a resident fall

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
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 (1) (c)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident plan of care sat out clear directions to staff, in applying foot pedals when they were transporting the resident to prevent a fall that resulted in injuries.

Sources: Resident's clinical records, Critical Incident Report and interview with the Director of Care.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could easily be seen, accessed and used by residents. A resident did not have access to their call bell to alert staff when they required assistance.

Sources: review of resident plan of care, home's investigation notes, interview with a resident, and staff

WRITTEN NOTIFICATION: Skin And Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity after a fall, that the resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Sources: Resident's clinical records, Critical Incident Report and interview with the Director of Care.

WRITTEN NOTIFICATION: Maintenance services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that procedures were developed and

implemented for electrical and non-electrical equipment, specifically bed systems to ensure that they were kept in good repair and maintained at a level that met manufacturer's specifications.

No maintenance procedures were developed for the licensee's bed systems which included what components were to be inspected, by whom and how often to ensure that the bed systems were maintained as per manufacturer's specifications (a proactive process).

Current bed maintenance program is mostly remedial whereby maintenance staff respond to disrepair. Maintenance records submitted by staff over the last six months included many reports of broken footboards and motor failures, including a 14-year-old bed system for a resident, whereby the head of the bed dropped due to a motor failure while the resident was in the bed.

Sources: Interviews with the Administrator, Environmental Services Supervisor and maintenance person and review of bed inspection checklist, and maintenance request submissions

WRITTEN NOTIFICATION: Maintenance Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee failed to ensure that the shower chair used by residents was kept in

good state of repair when the footrests were removed and not replaced. A resident sustained an injury of impaired skin integrity when they hit their leg on the metal object that was designed to hold the footrests.

Sources: review of the resident's progress notes, skin and wound assessments, pictures of the shower chair, maintenance care logs and interview with staff

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to ensure that new orders for a resident were processed upon receipt of the Nurse Practitioner's new orders.

In accordance with O. Reg 246/22 s. 123 (3)(a), the licensee is required to ensure that there is a medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Specifically, the licensee did not comply with MediSystem Policy "PointClickCare (PCC) Integration Medication Management (IMM): Order Processing Procedures," which stated that non-drug related orders must be entered in PCC by nursing staff upon receipt of prescriber instruction.

Failure to comply with their policy, put a resident at risk for health deterioration.

Sources: Resident's clinical records, Investigation Notes, Interview with staff

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