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

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Public Report

Report Issue Date: April 24, 2025

Inspection Number: 2025-1463-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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): April 7-11, 15-17, 22-24, 2025

The following intake(s) were inspected:

- Intake #00136205, CI #2981-000003-25 - fall of a resident resulting in injury.
- Intake #00137187, CI #2981-000016-25 - staff to resident neglect.
- Intake #00137485, CI #2981-000018-25 - improper care of a resident.
- Intake #00137541 - complainant regarding the care of a resident.
- Intake #00137706 -Follow-up #: 1 - O. Reg. 246/22 - s. 78 (2) (d)-Menu planning
- Intake #00137707 -Follow-up #: 1 - FLTCA, 2021 - s. 25 (1)-Policy to promote zero tolerance
- Intake #00138641, CI #2981-000022-25 - allegation of improper care of a resident.
- Intake #00139747, CI #2981-000026-25 - fall of a resident resulting in injury.
- Intake #00140955, CI #2981-000028-25 - outbreak.

- Intake #00142052, CI #2981-000032-25 - fall of a resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1463-0001 related to O. Reg. 246/22, s. 78 (2) (d)
Order #001 from Inspection #2025-1463-0001 related to FLTCA, 2021, s. 25 (1)

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A falls prevention intervention was discontinued on two separate occasions. Shortly after both times, the resident sustained falls.

The resident was reassessed each time the intervention was discontinued, however, the frontline staff notes during this time identified the resident continued to require the intervention. The home failed to ensure there was collaboration between the nursing management team and the frontline staff and that their assessments of the residents needs in relation to the falls prevention interventions were integrated and consistent with and complemented each other.

Sources: Review of a resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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.

The licensee has failed to ensure that the home immediately reported an allegation of improper care to the Director.

According to FLTCA s. 154 (3), the licensee is vicariously liable when a staff member has failed to comply with subsection 28 (1).

A nurse allegedly withheld medication from a resident. The home was not made aware of this allegation until almost two weeks later.

Source: Critical incident report, investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A resident's transfer status was changed from 2-person assistance to the mechanical lift. On multiple occasions after this date, the resident was transferred with 2-person assistance.

Sources: Resident's care plan; Homes investigation notes; Interview with ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the falls prevention and management program when strategies to reduce or mitigate falls for a resident were not implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there is a falls prevention and management program that, at a minimum, includes strategies to reduce or mitigate falls, and must be complied with.

a) A resident was at risk for falls and had a specific behaviour that increased the risk of injury during a fall. When the home did not implement strategies to prevent this behaviour, the resident had a fall and sustained several injuries.

Sources: falls prevention program last revised February 2, 2024, care plan, progress note, diagnostic imaging, interviews with staff.

b) A resident was required to have fall interventions in place when they were in bed. The resident was observed to not have these interventions in place when they were in bed.

Sources: Observation, falls prevention program last revised February 2, 2024, care plan, interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence, and that the plan was implemented.

A resident's care plan stated they were to be toileted at specific times and as needed. On a specified date, the resident was not toileted or changed at the specified times and this may have contributed to the resident's subsequent fall.

Sources: Resident's care plan; Homes investigation notes; interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (f)
Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

The licensee failed to ensure that continence care products were available and accessible to residents and staff at all times. When a resident required the application of a continence product there were no products readily available to staff.

Sources: home's investigation notes, pictures, interview with a staff member.

WRITTEN NOTIFICATION: Pain Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to comply with the home's pain management program when strategies were not implemented to manage a resident's pain.

In accordance with O. Reg. 246/22, s. 11(1)(b), the licensee is required to ensure that written polices for pain management were complied with.

Specifically, the home's pain management policy stated the pain management program focused on strategies to manage pain including non-pharmacologic interventions, equipment, supplies, devices and assistive aids, and comfort care measures. A resident had a fall that resulted in pain. Pain management strategies

and appropriate pain assessments were not implemented until sixteen hours after the fall despite the resident having pain.

Sources: review of the residents clinical records, hospital discharge records, and interviews with staff.

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident developed acute pain that was not relieved by initial interventions, that they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident had a fall, developed pain approximately 45 minutes later and an intervention was implemented. The resident continued to have pain for twenty three hours, and was diagnosed with an injury, before a pain assessment using a clinically appropriate assessment tool was completed.

Sources: Review of the resident's clinical records, the home's policy titled "Pain Management Policy and Procedure revised May 25, 2024" and interview with a staff member.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 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).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was not given a medication at a scheduled hour on two different days. The resident was observed by staff to be weak, tired, and confused.

Source: Medication incident report, prescribed order, documentation survey report, home's investigation notes, interviews with the resident and staff.