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: May 29, 2025
Inspection Number: 2025-1124-0005
Inspection Type: Critical Incident
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Tavistock, Tavistock

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27-29, 2025

The following intake(s) were inspected:

- Intake: #00145068- CI #2614-000010-25 related to fall of a resident.
- Intake: #00147158- CI #2614-000012-25 related to fall of a resident.

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

Medication Management
Falls Prevention and Management

INSPECTION RESULTS

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: 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.

The licensee failed to ensure that fall prevention and management strategies were implemented for a resident in relation to the use of a specific fall prevention intervention. During an observation conducted, the resident did not have a falls prevention intervention implemented. Staff implemented a falls prevention intervention immediately after the concern was raised by the inspector.

Sources: Observation of the resident; review of the resident's Plan of Care tasks and documentation survey report; and an interview with personal support workers and a director of care.

Date Remedy Implemented: May 28, 2025

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs

s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident.

The licensee failed to ensure that residents did not administer a drug to themselves unless the administration had been approved by the prescriber.

During an observation, it was noted that medications for residents were left unattended on a dining table during lunch. The staff member responsible did not remain with the residents to confirm ingestion of the medications and was observed administering medications to other residents outside the dining area. Additionally, the staff member documented the administration in the Medication Administration Record (MAR) prior to the actual administration, failing to ensure safe and accurate medication practices.

The home's medication administration policies required staff to observe residents post-administration to ensure full ingestion and to remain with the resident until the medication was taken. Neither residents had a care plan authorizing self-administration of medication. This practice posed a risk to resident safety and contravened physician orders.

Sources: Medication administration observation in the home area; interviews with registered staff, director of care, and assistant director of care; review of residents' clinical records; and review of the home's medication administration policies and procedures.