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

London District
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Public Report

Report Issue Date: August 6, 2025

Inspection Number: 2025-1124-0006

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): July 31, 2025, and August 1, 5, and 6, 2025.

The following intake(s) were inspected:

- Intake: #00150827 - Critical Incident (CI) #2614-000013-25 related to falls prevention and management
- Intake: #00151972 - CI #2614-000014-25 related to falls prevention and management

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

Skin and Wound Prevention and Management
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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 a staff member used a safe transferring device when assisting a resident with a transfer.

Sources: record review of CI #2614-000014-25, the home's investigation notes, and the resident's health care records, and staff interviews.

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) 4.
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:
4. A pain management program to identify pain in residents and manage pain.

The licensee has failed to ensure their pain management program to identify pain in residents and manage pain was complied with.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to develop and implement a pain management program, and this program must be complied with.

Specifically, the licensee has failed to ensure a staff member followed the home's pain management program when a resident expressed pain.

Sources: record review of the home's pain management program, and the resident's health care records, and staff interviews.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that a resident was assessed following a fall.

Sources: record review of CI #2614-000014-25, the home's investigation notes, the resident's health care records, and the home's falls prevention and management program, and staff interviews.