

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130, avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 11, 2021	2021_777731_0007	003269-21	Critical Incident System

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**Licensee/Titulaire de permis**

peopleCare Communities Inc.  
735 Bridge Street West Waterloo ON N2V 2H1

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**Long-Term Care Home/Foyer de soins de longue durée**

peopleCare Oakcrossing London  
1242 Oakcrossing Road London ON N6H 0G2

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

KRISTEN MURRAY (731)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 9, 2021.**

**The following Critical Incident intakes were completed within this inspection:**

**Related to falls prevention**

**Critical Incident Log # 003269-21 / CI 2980-000005-21**

**An IPAC inspection was also completed during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), an Associate Director of Care (ADOC), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), and an Environmental Services Staff.**

**The inspector also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.**

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

**Falls Prevention**

**Infection Prevention and Control**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident sustained a fall and a post-fall assessment was not completed for the resident following the fall. The home's fall prevention and management policy required a member of the registered nursing staff to complete a post-fall assessment following a resident fall. There was increased risk to the resident related to the post-fall assessment not being completed after their fall.

Sources: Fall Prevention & Management Program – Falls Risk Factors & Related Interventions policy (number 005190.00); a resident's progress notes and assessments; and interviews with a Registered Practical Nurse (RPN) and other staff. [s. 49. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

**Issued on this 18th day of March, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**