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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London, ON, N6A 5R2
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Public Report

Report Issue Date: February 14, 2025

Inspection Number: 2025-1462-0002

Inspection Type:
Critical Incident

Licensee: peopleCare Communities Inc.

Long Term Care Home and City: peopleCare Oakcrossing London, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11, 12, 13 and 14, 2025

The following intake(s) were inspected:

- Intake: #00133210 - Critical Incident System (CIS) #2980-000067-24 concerning an outbreak in the home and concerns about the operation of the home
- Intake: #00134602 - CIS #2980-000070-24 concerning alleged improper care of a resident
- Intake: #00138498 - CIS #2980-000005-25 concerning a resident fall with injury

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure a written complaint alleging risk of harm to multiple residents was immediately forwarded to the Director.

Sources: review of a CIS report and the written complaint, and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
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:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that when a resident fell, the Head Injury Routine (HIR) was monitored.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injury Routine policy and Fall Management policy which was part of the licensee's Falls Prevention and Management Program.

During an interview with Assistant Director of Care (ADOC) and Director of Care (DOC), they reviewed the HIR for a resident who had a fall and said that it contained many missing required assessments.

Sources: review of a resident's HIR, progress notes, post fall assessments, the home's Falls Management Program and HIR policy, and interview with a ADOC and DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure the Ministry's toll-free telephone number for making complaints about homes, its hours of service, and the contact information for the patient ombudsman was included in the response to a person who submitted a written complaint.

Sources: review of a CIS report, the complaint's "Complaint Record Form", and the written responses to the complainant, and an interview with the DOC.