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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: September 26, 2025
Inspection Number: 2025-1122-0004
Inspection Type: Critical Incident
Licensee: peopleCare Communities Inc.
Long Term Care Home and City: peopleCare Meaford LTC, Meaford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24, 25, and 26, 2025

The following intake(s) were inspected:
-Intake: #00155254: Falls Prevention and Management

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 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 has failed to ensure that fall risk assessment for a resident was completed accurately to 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.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for their falls prevention and management program were complied. The home's falls prevention policy indicated that registered staff would complete a falls assessment ensuring all sections of the tool were completed. As per the policy, residents that are High Risk with a fall would be identified by a falling leaf in an area that is well known and visible to staff. A falling leaf would be posted at the resident's bedside to identify the resident at high risk, in some homes there was also a falling leaf symbol on the frame of the door.

The resident was incorrectly assessed as a moderate fall risk, which resulted in staff being unaware that the resident was high risk for falls and potentially adding more interventions to prevent further falls.

Sources: Resident's clinical records; The home' Fall Prevention & Management Policy; Reference No.: 005190.00; Created on: October 18, 2015; Reviewed on: December 11, 2024; and Staff interviews

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