

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

130 Dufferin Avenue, 4th Floor London, ON, N6A 5R2 Telephone: (800) 663-3775

Public Report

Report Issue Date: April 10, 2025

Inspection Number: 2025-1462-0003

Inspection Type:

Complaint

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): April 3, 4, 7, 8, 9, 10, 2025

The following intake(s) were inspected:

- Intake: #00140496 (CIS 2980-000007-25) related to food and nutrition
- Intake: #00141512 (CIS 2980-000011-25) related to pest control
- Intake: #00141543 (CIS 2980-000012-25) related to air temperatures
- Intake: #00142721 (CIS 2980-000016-25) related to the fall of a resident
- Intake: #00142929 Complaint related to the fall of a resident

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

Food, Nutrition and Hydration Safe and Secure Home Falls Prevention and Management

INSPECTION RESULTS



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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 (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 failed to ensure that when a resident had a fall, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that all sections of the home's post fall assessment tool were completed in full.

When the resident had fallen, staff did not complete post fall vitals as required as part of the post-fall assessment tool.

Sources: Resident progress notes and post fall assessments, Home's Fall Prevention & Management Program Policy, and staff interviews.