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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: January 8, 2026
Inspection Number: 2025-1615-0009
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of Halton
Long Term Care Home and City: Post Inn Village, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 15, 16, 18, 19, 22, 29, 30, 2025 and January 2, 5, 6, 7, 8, 2026.
The inspection occurred offsite on the following date(s): December 23, 24, 31, 2025.

The following intake(s) were inspected:
-Intake: #00162591 - Critical Incident (CI) #M620-000063-25 - related to Infection Prevention and Control (IPAC).
-Intake: #00162786 - Complaint related to multiple care concerns.
-Intake: #00162867 - CI #M620-000065-25 - related to improper care of a resident.
-Intake: #00162961 - CI #M620-000066-25 - related to emergency.
-Intake: #00163554 - Complaint related to concerns regarding communication and response system.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes indicated, under section 10.3, that the licensee was required to ensure that hand washing facilities were provisioned with appropriate supplies.

i) A hand soap dispenser in the resident lounge area on a home area was found to be empty and unavailable for use.

Sources: Observations; interview with staff, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023).

B) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes indicated, under section 9.1 f), that the licensee would ensure that Additional Precautions were followed in the IPAC program, including appropriate selection application, removal and disposal of personal protective equipment (PPE).

i) A resident was on droplet contact additional precautions, including the requirement to wear a mask, gown, gloves, and eye protection. A staff member did not wear the required eye protection while they were in close contact with the resident.

Sources: Observations, resident's clinical records, staff interview, The Infection Prevention and Control Program (Procedure Number: 03-03-01) last revised February 2024, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023).

ii) A resident was on contact precautions and there was a requirement to wear a gown and gloves upon entering the room. A staff member did not wear the required gown when in resident’s room.

Sources: Observations, resident's clinical records, staff interview, The Infection Prevention and Control Program (Procedure Number: 03-03-01) last revised February 2024, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023).

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

A written complaint was made to the home related to concerns with care of a resident. The home has not completed a formal investigation into the concerns and there was no written record of the investigation.

Sources: Review of the critical incident (CI) file which included the complaint letter, response letter to the complainant and the action plan; interview with the Senior Nursing Manager (SNM).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The long-term care home declared an outbreak on November 12, 2025. The outbreak was not reported to the Director until November 13, 2025.

Sources: IPAC Lead interview, Critical Incident System (CIS) Report, Critical Incident Reporting Policy (last revised October 2025).

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

A resident was on an identified therapy and staff identified that an order was needed for this therapy as it was considered a drug. However, there was no physician's order for the identified therapy.

Sources: Observation; review of resident's Physician's Orders; interviews with staff.

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. The home is to develop and implement a process for ensuring that the choice sheet is updated as soon as the dietary changes are made, including but not limited to diet order changes, and the updated choice sheet is communicated with the front line staff. Maintain a written record of the process developed, changes made, and how the process was implemented.

2. Specifically, educate registered staff, personal support workers (PSWs), and dietary aides on an identified home area on the above-mentioned process and maintain a written record of the training including the content of the education, the date the training took place, the staff member(s) who received the education, and the staff member(s) who provided the education.

3. For a two week period the home shall:
a) complete audits, at a minimum of four times weekly at different meal times, to ensure that the residents' plan of care related to their diet order is being followed for three randomly selected residents with modified diets.
b) maintain a record of these audits with the name of the residents being audited, type of modified diet they are on, whether they received their diet as per their plan of care, the staff member(s) who completed the audit, and any remedial actions taken, if any discrepancies are noted in the audits.

4. Complete audits three times a week at different meal times, for two weeks, to ensure an identified resident receives the correct texture. A record of the audits shall be kept for review.

5. Review the home’s revised system for identifying risks of a health condition and make necessary revisions to ensure it addresses early signs of the condition and includes strategies to prevent it. Keep a record of gaps identified and any new revisions made to the system, including dates of when the revisions were implemented.

6. Review and revise the nurse dehydration assessment to ensure it is based on evidence-based practices.

7. Educate all PSW staff on the new revised system. Educate all registered staff on the revised system and revised assessment tool. Keep a record of the training material and

a list of staff who participated, and the dates of when the education was provided.

Grounds

A) In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and procedures developed for the nutritional care and hydration program were complied with. Specifically, the home's procedure on diet order requisition indicated that the choice sheet was to be updated as soon as the diet order requisition was completed to communicate any dietary changes, including diet order changes, which did not occur for a resident when their diet order changed.

A resident had a known nutritional risk related to a diagnosis. The resident was placed on a trial for a specific diet and texture. During a meal service, the resident was served an incorrect diet texture. As a result, the resident experienced an incident requiring an emergency response. The resident was sent to the hospital for further assessment and treatment.

The failure to ensure the interventions to mitigate the risk for this resident were implemented resulted in the resident receiving the incorrect texture which resulted in an emergency situation.

Sources: Resident's records, home's 'Diet Requisition Procedure' (last reviewed August 2025), and interviews with staff.

B) A resident was provided with the incorrect fluid consistency during their lunch meal, contrary to their prescribed care plan. This placed them at risk for aspiration.

Sources: Observation; review of resident's care plan, interviews with staff.

C) Interventions were not implemented to manage a resident's risk for a health condition for a specified period of time. The resident’s plan of care identified the resident was at risk for this health condition, and had additional nutritional risks requiring other interventions. The resident was also on and had additional nutritional risks requiring other interventions. The resident was also on medication that placed them at nutritional risk.

The resident had an identified target for fluid intake, and it was less than the target for

an identified period of time. Their food intake also decreased. There was no referral made to the registered dietitian (RD) and no other interventions were implemented to prevent a health status decline. An evaluation of the resident’s identified status was not completed on a specific time period as per the home’s policy when the resident's fluid intake was less than their target. The home used an assessment tool which the home identified contained gaps and needed to be revised. There was no system to evaluate or address early signs of a health condition as per the assessment tool used.

Strategies to address the risk for a health condition were not implemented until an identified date when the home received results of a test and the resident was sent to hospital for further treatment.

Sources: Review of resident's health records, policy "Hydration Program Procedure" (revised Sept 2024); interviews with staff.

This order must be complied with by April 2, 2026

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.