

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: March 26, 2026

Inspection Number: 2026-1615-0001

Inspection Type:
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): March 16, 18-20, 23-26, 2026.

The following intake(s) were inspected:

-Intake: #00165661 - Critical Incident (CI) M620-000070-25 - Falls prevention and management.

-Intake: #00169396 - CI M620-000011-26 - Prevention of abuse and neglect.

-Intake: #00172629 - CI M620-000020-26 - Improper/Incompetent treatment or care of a resident.

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

- Resident Care and Support Services
- Continence Care
- Housekeeping, Laundry and Maintenance Services
- Medication Management
- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Palliative Care
- Recreational and Social Activities
- Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A) A resident's substitute decision maker (SDM) was not provided the opportunity to fully participate in developing or implementing the resident's plan of care, when there were changes made to the resident's medication orders and there was no information to indicate the resident's SDM provided consent.

Sources: Progress notes, Order Audit Report, MediSystem Digiorde, interview with Registered staff.

B) A resident's SDM was not provided the opportunity to fully participate in developing or implementing the resident's plan of care when interventions were implemented without their input.

Sources: A resident's care plan, complaint letter, interviews with Life Enrichment Therapists.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (3) 16.

Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

16. Activity patterns and pursuits.

A resident's plan of care was not based on an interdisciplinary assessment until approximately four months after their admission to the home.

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Sources: A resident's care plan, Life Enrichment Assessment Policy, LE-Rec/Leisure Assessment, interviews with Life Enrichment Therapist.

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 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

A resident experienced a fall on a specified date in 2025, and was sent to hospital the same day to rule out fracture. Three days later, the resident was diagnosed with a fracture. The Director was not informed until eight (8) business days after the incident.

Sources: CI M620-000070-25, resident's care plan and progress notes, interview with Registered staff.