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
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Original Public Report

Report Issue Date: December 13, 2022	
Inspection Number: 2022-1618-0002	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Creek Way Village, Burlington	
Lead Inspector Karlee Zwierschke (740732)	**Inspector Digital Signature** Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2022.12.13 10:12:31 -05'00'
Additional Inspector(s) Daria Trzos (561)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 6-8, 2022

The following intake(s) were inspected:

- Intake #00002672, #00003191, #00003278, #00003414, #00004165, #00004915, and #00007240 related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management
Medication Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (e) point-of-care signage indicating that enhanced IPAC control measures are in place.

Rational and Summary
Additional precaution signage for a room was missing. Care plan for resident indicated that the resident was on additional precautions. PSW confirmed that the additional precaution signage was missing. PSW placed a new additional precaution sign by the room.

Sources: observations, interview with PSW, care plan

Date Remedy Implemented: December 7, 2022

[740732]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for that resident.

Rationale and Summary
Resident had identified falls prevention interventions in place. PSW identified that these were current falls preventions interventions for the resident. Care plan for resident did not have the identified interventions listed. RAI Coordinator identified that these were current interventions and should have been in the care plan.

Sources: resident care plan, interview with and RAI Coordinator, observations

[740732]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

Rationale and Summary
RN was observed leaving the medication cart and screen unlocked when walking away to administer medication. Following the observation RN identified that the medication cart is to be locked any time they walk away. Administrator confirmed that the expectation is that registered staff lock the medication cart and close the screen any time they walk away.

Sources: observations, interview with RN, interview with administrator

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