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
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Original Public Report

Report Issue Date: December 7, 2023	
Inspection Number: 2023-1615-0004	
Inspection Type: Critical Incident	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Post Inn Village, Oakville	
Lead Inspector Julie D'Alessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.12.08 10:31:35 -05'00'
Additional Inspector(s) Cassandra Taylor (725)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, and 6, 2023.

The following intake(s) were inspected:

- Intake #00092500/ CI#M620-000027-23 related to fall prevention and management
- Intake #00092661/ CI #M620-000030-23 related to resident care and support services

The following intakes were completed in this inspection: Intake #00088622/CI #M620-000022-23 and Intake #00084297/CI #M620-000012-23 related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and 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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A resident's fall prevention care plan was reviewed. During interviews, staff indicated that the resident had a fall intervention in place, and it was also observed that the fall intervention was in place. A review of the resident's care plan did not include the fall intervention. The Administrator indicated that the fall intervention should have been in the care plan.

During record review on a later date, it was noted that the resident's care plan had been updated and included the fall intervention.

Sources: Resident records, observation, and staff interviews.
[725]

Date Remedy Implemented: December 4, 2023

WRITTEN NOTIFICATION: Foot Care Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Introduction:
The licensee failed to ensure that a resident received preventive foot care services as scheduled.

Summary and Rationale:
A progress note indicated that there was a concern that the resident was not receiving foot care. Upon further review of the resident's clinical chart there was documentation to support that foot care had not been provided as scheduled.

During an interview with the home's Senior Nurse Manager, they stated that foot care was not provided to the resident as scheduled and should have been.

Sources: Resident's clinical chart and interview with the Senior Nurse Manager.
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