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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Public Report

Report Issue Date: May 7, 2025
Inspection Number: 2025-1615-0003
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): April 29, 30, 2025 and May 1, 2, 5-7, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00139838 -CI 620-000009-25 - related to prevention of abuse and neglect.
- Intake: #00141537 -CI 620-000015-25 - related to resident care and services.

The following complaint intake(s) were inspected:

- Intake: #00143680 - related to resident care and services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 17.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
17. Every resident has the right to be told both who is responsible for and who is providing the resident's direct care.

The licensee has failed to ensure that when a staff provided care to a resident that they introduced themselves and communicated to the resident the care being provided.

Sources: resident's clinical records, the home's client response documents, and interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when the home was informed of potential improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, that it was immediately reported to the Director.

Sources: Critical Incident Report and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure staff used safe transferring techniques when transferring a resident using a lift, when staff did not communicate to the resident during the transfer and applied their clothing while still in the lift, hovering over their wheelchair.

Sources: the home's client response documents, Lift, Transfer and Repositioning Program Policy dated September 2010, and interview with staff.

WRITTEN NOTIFICATION: Dress

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the

home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that staff assisted with putting a resident 's clothing on after providing care, in keeping with the resident's preferences.

Sources: resident's clinical records, the home's client response documents, and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that a resident, who was dependent on staff for repositioning, was repositioned every two hours.

Sources: The home's client response documents, resident's clinical records, and interview with staff.