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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 31, 2023	
Inspection Number: 2023-1436-0006	
Inspection Type: Critical Incident	
Licensee: 1245556 Ontario Inc.	
Long Term Care Home and City: Burton Manor, Brampton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.10.31 13:37:59 -04'00'
Additional Inspector(s) Janet Groux (606)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-20, 2023.
The inspection occurred offsite on the following date(s): October 19, 2023.

The following critical incidents (CI) intakes were inspected:

- Intake #00085678, CI #2953-000017-23, intake: #00088402, CI #2953-000019-23, and intake #00088809, CI #2953-000023-23, related to falls prevention and management
- Intake #00092009, CI #2953-000028-23, related to alleged neglect.

The following intake was completed in this inspection:

- Intake #00088610, CI #2953-000021-23, related to falls prevention and management.

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning techniques when they assisted a resident with care.

Rationale and Summary

A PSW did not use safe transferring and positioning techniques when they assisted a resident with a specific care need. As a result of the incident, the resident was injured.

The home's Assistant Director of Care (ADOC)/Former Falls Lead and the Executive Director said staff should have followed the directions as indicated in the resident's plan of care for the level and type of help they required.

Sources: a critical incident, a resident's clinical records, the home's investigation notes, and interviews with a PSW, two RPNs, the home's ADOC/Former Falls Lead, and the Executive Director. [758]