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
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Public Report

Report Issue Date: March 19, 2025

Inspection Number: 2025-1436-0001

Inspection Type:
Complaint
Critical Incident

Licensee: 1245556 Ontario Inc.

Long Term Care Home and City: Burton Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 6-7, 10-14, and 18, 2025
The inspection occurred offsite on the following dates: March 17, and 18, 2025

The following Critical Incident System (CIS) intakes were inspected:

- Intake #00135442, related to a respiratory outbreak
- Intake #00137278, #00138714, and #00139479, related to allegations of resident abuse.

The following complaint intakes were inspected:

- Intake #00137301, and #00138666, related to concerns regarding skin and wound, nutrition and hydration programs, resident care and support services, and laundry services

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities

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: O. Reg. 246/22, s. 102 (2) (a)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(a) any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance; and

The licensee has failed to ensure that the additional screening requirement under section 11.6 of the Infection Prevention and Control (IPAC) Standard issued by the Director was followed.

Specifically, the licensee has failed to ensure that signage that listed the signs and symptoms of infectious diseases for self-monitoring was posted at the entrances

and throughout the home.

On March 10, 2025, signage that listed the signs and symptoms of infectious diseases for self-monitoring was posted on the entrance door of each Resident Home Area, in addition to the home's main entrance.

Sources: Long-Term Care Homes Inspector's observations, IPAC Standard (2023) and an interview with the IPAC Lead.

Date Remedy Implemented: March 10, 2025

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) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to a resident.

A resident's discontinued treatments for two areas of skin concerns were not immediately removed from the electronic Treatment Administration Record (eTAR) and were signed off by the registered staff as administered on multiple dates and times after being discontinued by the Nurse Practitioner.

Sources: a resident's clinical records, and interviews with a Registered Nurse (RN), and the Director of Care (DOC).

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #003 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.

The licensee failed to ensure that a resident's Substitute Decision-Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The resident's SDM agreed for the resident to continue with the new changes in their diet texture for the next two weeks in order to assess change in the resident's meal intake.

There was no follow-up made to the resident's SDM following the two weeks, regarding the resident's intake, and how they were tolerating the new diet texture.

Sources: a resident's clinical records, and interviews with the DOC, and the Registered Dietitian (RD).

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the written plan of care was provided to a resident as specified in the plan. Registered nursing staff used a skin treatment that was not prescribed by the resident's physician, one month after the physician ordered not to use the specific treatment.

Sources: a resident's clinical records, and interviews with an RN, and the DOC.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by a staff member.

For approximately two months, a staff involved in inappropriate behaviours and remarks towards a resident while they were providing care and services to the resident. By not protecting the resident from abuse, the resident was subjected to emotional distress and felt uncomfortable with the staff providing care and services to them and other residents.

Sources: a critical incident report, the home's investigation notes and interviews with a resident, a Social Worker and the Executive Director.

WRITTEN NOTIFICATION: Social work and social services work

qualifications

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 69
Social work and social services work qualifications
s. 69. Every licensee of a long-term care home shall ensure that social workers or social service workers who provide services in the home are registered under the Social Work and Social Service Work Act, 1998.

The licensee has failed to ensure that a Social Service Worker (SSW) who provided services in the home was registered under the Social Work and Social Service Work Act, 1998.

Specifically, a staff who was employed as a SSW, and provided social services in the home for about two months, did not have a registration with the Ontario College of Social Workers and Social Service Workers as required.

Sources: an employee's file, and an interview with the Executive Director.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee failed to ensure that the weight monitoring policy was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the nutritional care and hydration program, were complied with.

A resident had a weight loss of more than two kilograms compared with the previous month. The staff did not re-weigh the resident at that time, as required.

Sources: a resident's clinical records, the home's Weight Monitoring policy (December 2024) and interviews with the DOC, and the RD.

WRITTEN NOTIFICATION: Medication management system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that the home's Medication Pass policy developed for the medication management system was followed for a resident.

In accordance with O. Reg 246/22, s. 123(3) the written policies and protocols for the medication management system must be implemented. Specifically, the Medication Pass policy directed the registered nursing staff to complete specific steps before and after administering medication to residents and document the administration of

the resident's electronic Medication Administration record (eMAR).

On one occasion, two Registered Practical Nurses (RPNs) did not follow the steps listed in the home's policy when they administered medications and documented the medications administered to a resident. When staff did not follow the directions listed in the home's Medication Pass policy, they could not ensure accurate medication administration and documentation.

Sources: a resident's clinical records, and interviews with RPNs, and the DOC.