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

Public Report

Report Issue Date: July 23, 2025
Inspection Number: 2025-1436-0002
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: July 15-18, and 22-23, 2025

The following intakes were inspected:

- Intake #00147152, concerns regarding a resident's care and alleged abuse
- Intake #00147221, regarding abuse
- Intake #00148360, regarding falls prevention and management

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

Resident Care and Support Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan, which increased the resident's risk of injury.

Sources: Long-Term Care Homes (LTCH) Inspector's observation, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint regarding a resident's care and alleged abuse was immediately reported to the Director, limiting the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report, and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Prevention of abuse and neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was immediately informed of the results of the investigation regarding an allegation of resident abuse.

Sources: a critical incident report, the home's investigation notes, a resident's clinical records and an interview with the DOC.

WRITTEN NOTIFICATION: Reporting and complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that the response provided to the person who made a complaint regarding a resident's care and alleged abuse, included an explanation of the actions taken regarding the allegation of abuse and the reason why it was determined that the complaint was unfounded.

Sources: a critical incident report, the home's investigation notes and an interview with the DOC.