

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: April 1, 2026

Inspection Number: 2026-1436-0002

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 date(s): March 3-6, 9-10, 17-19, 23-27, 30-31, 2026 and April 1, 2026.

The following intake(s) were inspected:

- Intake: #00167355, related to prevention of abuse and neglect.
- Intake: #00167418, a complaint related to food, nutrition and hydration, prevention of abuse and neglect, resident care and support services, residents' rights and choices, staffing, training and care standards.
- Intake: #00173123, a complaint related to medication management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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Residents' Rights and Choices

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) 16.

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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

On a specific date, a resident received continence care that was not in a manner consistent with their assessed needs.

Sources: The resident's clinical records, the Long-Term Care Home's (LTCH's) internal investigation, a Personal Support Worker's (PSW's) disciplinary letter, interviews with staff.

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,

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

A resident's written plan of care did not include clear directions to staff regarding their recreational preferences and associated support needs.

Sources: The resident's clinical records, the LTCH's policy, email correspondence between the LTCH & Substitute Decision Maker (SDM), interviews with staff.



**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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