Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 3, 2023	
Inspection Number: 2022-1436-0003	
Inspection Type: Critical Incident System	
Licensee: 1245556 Ontario Inc.	
Long Term Care Home and City: Burton Manor, Brampton	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature**
Additional Inspector(s) Yami Salam (000688) was present during the inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 8-9, 13-16 and 19, 2022.

The following intake(s) were inspected:
• Intake #00008992 [Critical Incident System (CIS) #2953-000031-22] related to falls prevention and management.
• Intake #00012403 [CIS #2953-000032-22] related to an unexpected death of a resident.

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

Infection Prevention and Control
Falls Prevention and Management
Food, Nutrition and Hydration

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 74 (2) (c)

The licensee has failed to comply with the process of updating nourishment cart diet lists.

In accordance with O. Reg 246/22 s.11(1)(b), the licensee is required to ensure the nutrition care and hydration program includes the implementation of interventions to mitigate and manage identified risks and is complied with.

Rationale and Summary:
Specially, staff did not comply with the home’s Diet Order Policy that documented the Food and Nutrition Manager or Food Service Supervisor would keep the nourishment sheets updated to reflect the current diet order. Diet orders were to be reviewed to ensure all resident care documents matched.

At the time of inspection, the nourishment cart diet book in a resident home area was observed to contain outdated information. A staff member indicated the process was to use the diet list on the nourishment cart as reference when providing residents with their snacks.

The home’s Nutrition Manager (NM) confirmed the nourishment cart diet lists in specified resident home areas had not been updated for a specified period of time, due to being short staffed and transitioning to a new menu. Stickers with resident details were being placed on specialty snacks.

By failing to keep the nourishment cart books updated with accurate information, there was a risk that residents could have received items not appropriate for their diet, putting them at risk for choking.

Sources: Interviews with staff members, the home’s NM and Registered Dietitian (RD), Diet Order Policy, snack and dining room diet lists and a resident’s care plan.

[722374]

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WRITTEN NOTIFICATION: Plan of Care

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure a resident had their call bell within reach at all times.

Rationale and Summary
A resident was identified as a high risk for falls; their care plan indicated a falls intervention was to have their call bell within easy reach.

At the time of inspection, a resident was observed sitting in their room on the side of the bed closest to the door. At that time, the call bell cord was observed tied around the bed rail, with the end laying on the floor on the opposite side of the bed.

A staff member clarified the resident had been sitting in that location for approximately 90 minutes and the call bell should have been located beside the resident.

When the resident did not have access to their call bell while in their room, there was a risk the resident would not have been able to request assistance when required.

Sources: Observations at the time of inspection, a resident's care plan, Nurse Call System Policy and interviews with a resident, staff member and an Assistant Director of Care (ADOC).

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