

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: December 19, 2023	
Inspection Number: 2023-1436-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: 1245556 Ontario Inc.	
Long Term Care Home and City: Burton Manor, Brampton	
Lead Inspector Romela Villaspir (653)	Inspector Digital Signature
Additional Inspector Janet Groux (606)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 4-8, 12-14, 2023.

The following intake was inspected:

- Intake: #00099187 - PCI Inspection

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management

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Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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. 271 (1) (e)

The licensee failed to ensure that the home's continuous quality improvement initiative report was posted on the home's website.

Rationale and Summary

The home's continuous quality improvement initiative report titled "Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario report for 2023" was not posted on the home's website. The Executive Director (ED) acknowledged this.

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Sources: Burton Manor Long Term Care Home's Report 2022-2023; Interview with the Executive Director (ED). [606]

Date Remedy Implemented: December 14, 2023

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure that a resident's right to be afforded privacy in caring for their personal needs, was fully respected and promoted.

Rationale and Summary

A resident's family member informed the Inspector that the staff were not always maintaining the resident's privacy during care. This was observed by the Inspector during an observation.

The Director of Care (DOC) indicated that the home's expectation was for staff to maintain a resident's privacy during care.

Sources: Inspector #653's observation; Interviews with the resident's family member, a Personal Support Worker (PSW), and the DOC. [653]

WRITTEN NOTIFICATION: DRESS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 44

The licensee failed to ensure that a resident was dressed appropriately, suitable to the time of day.

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Rationale and Summary

On multiple occasions, a resident was placed in bed for a nap with their shoes on.

The DOC stated that the home's expectation was for the staff to remove the resident's shoes when putting them back to bed for a nap.

Sources: Inspector #653's observation; Interviews with the resident's family member, PSWs, and the DOC. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee failed to ensure all staff received annual training in all areas required under subsection 82 (7) of the Act.

Rationale and Summary

A) The 2022 training records on the home's Pain Management Program policy #005300.00 for PSWs, were not available for review. The Associate Director of Care (ADOC) said there were no training records found and acknowledged that all PSWs in 2022 were not provided training.

B) The home's training records for a Registered Practical Nurse (RPN) and a PSW identified the staff did not complete their training on the home's Falls Prevention and Management Program for 2022. The ADOC acknowledged this.

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Sources: Surge training records for Falls Prevention and Management; Interview with the ADOC. [606]