

**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**

<b>Report Issue Date:</b> December 30, 2025
<b>Inspection Number:</b> 2025-1573-0006
<b>Inspection Type:</b> Critical Incident
<b>Licensee:</b> The Regional Municipality of Peel
<b>Long Term Care Home and City:</b> Peel Manor, Brampton

**INSPECTION SUMMARY**

The inspection occurred onsite on the following dates: December 17-19, 22-24, 2025, and offsite on December 29, 2025.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00161485 related to responsive behaviours, and prevention of abuse and neglect of residents.
- Intake: #00161586 related to resident care and support services.
- Intake: #00164635 related to prevention of abuse and neglect and residents' bill of rights.

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

- Resident Care and Support Services
- Responsive Behaviours
- Prevention of Abuse and Neglect
- Residents' Rights and Choices

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## 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) 1.**

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A resident's right to be treated with courtesy and respect was not fully respected and promoted by a staff member on one occasion.

Sources: Critical Incident (CI) report, the home's internal investigation notes, employee file, resident's clinical health records, e-mail correspondences; Interviews with a Personal Support Worker (PSW), Registered Nurse (RN), and Supervisor of Care (SOC).

### WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

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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.

On one occasion, a PSW did not provide care to a resident as specified in their written plan of care.

Sources: CI report, the home's internal investigation notes, employee file, a resident's clinical health records, e-mail correspondences; Interviews with a PSW, RN, and SOC.

## **WRITTEN NOTIFICATION: Policy to promote zero tolerance**

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

### **Non-compliance with: FLTCA, 2021, s. 25 (1)**

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home's written policy to promote zero tolerance of abuse and neglect of residents, indicated specific guidelines for staff when allegations of abuse and/or neglect were reported.

A RN received information of an alleged incident of abuse and neglect that occurred during a previous shift. The RN did not comply with the guidelines outlined in home's written policy to promote zero tolerance of abuse and neglect of residents.

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Sources: CI report, Prevention, Reporting and Elimination of Abuse/ Neglect Policy #LTC1-05.01 last updated on April 12, 2023, the home's internal investigation notes, employee file, resident's clinical health records, e-mail correspondences; Interview with the SOC.

**WRITTEN NOTIFICATION: Reporting certain matters to Director**

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

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A resident reported an alleged incident of abuse and neglect to a RN, and the RN did not immediately report the information to the Director.

Sources: CI report, the home's internal investigation notes, employee file, resident's clinical health records, e-mail correspondences; Interview with the SOC.