

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

Hamilton District  
119 King Street West, 11th Floor  
Hamilton, ON, L8P 4Y7  
Telephone: (800) 461-7137

## Public Report

**Report Issue Date:** October 3, 2025

**Inspection Number:** 2025-1618-0004

**Inspection Type:**  
Critical Incident

**Licensee:** The Regional Municipality of Halton

**Long Term Care Home and City:** Creek Way Village, Burlington

## INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): October 1, 2, 3, 2025

The following intake (s) were inspected:

-Intake: #00158356 - [Critical Incident (CI): M623-000014-25] related to Resident Care and Support Services.

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

Resident Care and Support Services

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Right to be treated with respect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 2.**

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:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's right to their lifestyle and choices was fully respected as outlined in their plan of care regarding their rest and sleep pattern.

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**Sources:** Critical Incident Report, care plan, and staff interview.

## **WRITTEN NOTIFICATION: Right to freedom from abuse and neglect**

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

**Non-compliance with: FLTCA, 2021, s. 3 (1) 5.**

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:

5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident's rights to freedom of neglect was fully respected as acknowledged by staff of the home when the resident's did not receive the required support on a specified date.

**Sources:** Critical Incident Report, and staff interview.