

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: April 23, 2026

Inspection Number: 2026-1062-0004

Inspection Type:

Critical Incident

Licensee: 1230839 Ontario Limited

Long Term Care Home and City: Brouillette Manor, Tecumseh

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 21-23, 2026

The following intake(s) were inspected:

- Intake: #00172880- CI#2301-000003-26 Fall of resident
- Intake: #00172953-CI#2301-000004-26 Fall of resident

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

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Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

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,

(a) the planned care for the resident;

A resident utilized a specialized safety equipment as a fall safety measure, as observed on a specific date. This equipment was not included in the resident's plan of care. A Registered Nurse acknowledged that the equipment was not part of the written plan of care.

Sources: resident's clinical record and 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 (7)

Plan of care

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.

A resident's care related to transfers was not provided to the resident as specified in the plan of care. Resident's plan of care indicated mechanical lift with a specific size of sling for transfers. Two Personal Support Workers confirmed that they were not aware of the resident's plan of care despite the transfer logo posted in the room and that they utilized two persons for resident's transfers.

Sources: resident's clinical records and interview with staff.

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WRITTEN NOTIFICATION: Fall prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A critical incident was sent by the home to the Director related to an unwitnessed fall of a resident, that occurred on an identified date. The resident sustained a head injury during this fall and they did not have a Neurological Assessment Record initiated as required by the home's policy and confirmed by a Registered Nurse and the Director of Care.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure written policies developed for the falls prevention and management program were complied with.

Specifically, the home's policy indicated that "In case of a head injury unwitnessed fall, where it is suspected that the head may have sustained injury, staff to initiate a Neurological Assessment Record".

Sources: resident's clinical records and interview with Registered Staff