



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des Soins  
de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection prévue  
sous la Loi de 2007 sur les foyers  
de soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

Central West Service Area Office  
500 Weber Street North  
WATERLOO ON N2L 4E9  
Telephone: (888) 432-7901  
Facsimile: (519) 885-9454

Bureau régional de services du  
Centre-Ouest  
500 rue Weber Nord  
WATERLOO ON N2L 4E9  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-9454

**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 21, 2019	2019_792659_0004	002350-19	Complaint

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**Licensee/Titulaire de permis**

Corporation of the County of Bruce  
30 Park Street WALKERTON ON N0G 2V0

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**Long-Term Care Home/Foyer de soins de longue durée**

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce  
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JANETM EVANS (659)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 11 and 12, 2019.**

**The following intake was completed for this inspection:**

**Log #0002350-19\ IL-62835 CW, complaint related to potential neglect\improper care of a resident**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs).**

**Observations were completed for staff to resident interactions; general hygiene and grooming. A review of relevant records including but not limited to assessments, care plan, physician's orders, Point of Care was completed.**

**The following Inspection Protocols were used during this inspection:  
Hospitalization and Change in Condition  
Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director immediately, in as much detail as was possible in the circumstances, of an unexpected or sudden death.

On a specified date an identified resident was deceased. Review of the clinical record did not show evidence the resident was palliative or the death was expected.

Registered staff and PSWs who were interviewed stated the identified resident's death was unexpected.

The DOC and Administrator acknowledged that a critical incident was not submitted and the Director was not notified of the unexpected death.

The licensee failed to inform the Director immediately, in as much detail as is possible in the circumstances, of the unexpected death of the identified resident. [s. 107. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as is possible of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.***



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**Issued on this 21st day of February, 2019**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**