Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Public Report

Report Issue Date: May 22, 2025

Inspection Number: 2025-1533-0004

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Bruce

Long Term Care Home and City: Brucelea Haven Long Term Care Home - Corporation of the County of Bruce, Walkerton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7 - 9, 13 - 16, 20 - 22, 2025.

The following intake(s) were inspected:

- Intake: #00139855 - Responsive Behavoiurs, Prevention of Abuse and neglect
- Intakes: #00140770, #00146122, #00146326 and #00143344 - Falls Prevention and Management
- Intake: #00145498 - Continence and Skin and Wound Care

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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.

The licensee failed to ensure that, during a night shift a resident received turning, repositioning and continence care as per their care plan.

Sources: Internal investigation notes, Resident Care Plan and Kardex, and interviews with Nurse Manager.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident from the floor post-fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Safe Resident Handling Policy - Lift Definition Document, attachment A was complied with. The Safe Resident Handling Policy -

Lift Definition Document -attachment A, dated August 2023, stated that there is no manual resident lifting and all resident lifts must be completed with the use of resident lifting devices, such as a mechanical lift.

A resident had an unwitnessed fall in their room. Three staff members assisted the resident from the floor post-fall to their bed without the use of a mechanical lift.

Sources: Resident Clinical records, Safe Resident Handling Policy - Lift Definitions document, attachment A., and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that when a resident had an unwitnessed fall that they were monitored post fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program including that the resident is assessed and monitored, are complied with. The home's Falls Prevention and Management Policy, revised August 2024, directed the nurse to initiate a head injury routine if the resident fall is unwitnessed.

A resident had an unwitnessed fall and the head injury routine (HIR) was not initiated for this resident.

Sources: Resident Clinical Records, Falls Prevention and Management Policy. Policy, and interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

Licensee failed to ensure that the home took steps to minimize the risk of potentially harmful interactions between residents. A resident was observed by personal support worker (PSW) to be pulling another resident towards them. The resident was reported to have shown expressions of risk towards the other resident.

Sources: Internal investigation notes, Resident progress notes and care plan, and interviews with staff.