

**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

**Report Issue Date:** July 10, 2025

**Inspection Number:** 2025-1533-0006

**Inspection Type:**

Complaint  
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): July 3- 4, 7-10, 2025

The following intake(s) were inspected:

- Intake: #00146867: related to an outbreak
- Intake: #00147123: related to an outbreak
- Intake: #00147494: complaint related to outbreak precautions
- Intake: #00148159: complainant related to resident care
- Intake: #00148864: complainant related to resident care
- Intake: #00149733: related to an outbreak
- Intake: #00149796: complainant related to fall prevention and interventions
- Intake: #00152148: related to improper care of resident

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

Resident Care and Support Services  
Infection Prevention and Control

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Reporting and Complaints  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting certain matters to Director

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

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

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure when a registered nurse had reasonable grounds to suspect that improper or incompetent treatment of resident had occurred and which resulted in injury a critical incident was submitted to the Director.

**Sources:** resident's clinical record, interview with a RN