

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: June 10, 2025

Inspection Number: 2025-1597-0001

Inspection Type:

Critical Incident

Licensee: Corporation of the County of Huron

Long Term Care Home and City: Huronlea Home for the Aged, Brussels

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3 - 6, 2025

The following intake(s) were inspected:

- Intake: #00141388 - Unwitnessed fall of a resident, with injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

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s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to revise the plan of care for a resident related to falls, when interventions were not effective to prevent falls.

Sources: observation, plan of care, progress notes, interview with DOC, ADOC, PT and staff.

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff and the physiotherapist (PT) involved in the care of a resident collaborated when assessments completed over a four month period were not consistent or complemented one another.

Sources: Fall risk assessments, Care plan, Physio assessment Fall committee meeting minutes, interviews with ADOC, DOC, PT.