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

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

Public Report

Report Issue Date: August 21, 2025

Inspection Number: 2025-1062-0004

Inspection Type:
Complaint
Critical Incident

Licensee: 1230839 Ontario Limited

Long Term Care Home and City: Brouillette Manor, Tecumseh

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 14-15, 18, 20-21, 2025.

The following intakes were inspected:
- Intake: #00153069 - Critical Incident (CI) #2301-000017-25 related to falls prevention and management
- Intake: #00153070 - CI #2301-000018-25 related to falls prevention and management
- Intake: #00154325 - CI #2301-000020-25 related to alleged abuse
- Intake: #00154867 - complaint related to falls prevention and management

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

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to provide clear directions related to the use of a device in the written plan of care of a resident. On an identified date, a device was ordered for the resident and this was not updated in their written plan of care.

The licensee revised resident's written plan of care on August 18, 2025 to include the use of the device.

Sources: resident 's clinical record and interview with the Assistant Director of Care.

Date Remedy Implemented: August 18, 2025

WRITTEN NOTIFICATION: Fall prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that on a specific date, the staff used the equipment in the home in accordance with the manufacturer's instructions. Two steps of the manufacturer's instructions provided by the Assistant Director of Care were omitted by the staff during the equipment application to a resident. As a result, the resident sustained a fall and was transferred to the hospital.

Sources: review of resident's clinical record, review of manufacturer's instructions, interview with a Personal Support Worker and the Director of Care.