Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2022	2022_922119_0005	011490-21	Critical Incident System

Licensee/Titulaire de permis

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

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

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

JANIS SHKILNYK (706119), ROBERT SPIZZIRRI (705751)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 22-25, 2022.

The following intakes were completed within the critical incident inspection:

Log #011490-21, related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During the course of the inspection, the inspector(s) spoke with the acting Administrator/Director of Long Term Care and Senior Services, Administrator in training, Acting Director of Care (acting DOC), Director of Care (DOC), Environmental Services Supervisor (ESS), Registered Nurse/Resident Assessment Instrument-Minimum Data Set (RN/RAI-MDS) Coordinator, Registered Practical Nurse (RPN)/Wound Care Champion, Registered Practical Nurse (RPN), Personal Support Workers (PSW), Administrative Assistant, housekeeping, resident.

During this inspection, inspector(s) toured the home, observed residents and care provided to them, reviewed relevant clinical records, relevant policies, and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Skin and Wound Care

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that an allegation of neglect related to resident #001 was reported to the Director immediately.

The home received written correspondence alleging care and communication concerns for resident #001.

The allegations were not immediately reported to the Director. The acting Administrator confirmed that the expectation for reporting alleged incidents of abuse/neglect to the Director is immediate.

The potential risk of harm to resident #001 may have occurred as the Director was unable to take action, if required.

Sources: critical incident summary, interview with acting Administrator [s. 24. (1)]

Issued on this 1st day of March, 2022

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

Original report signed by the inspector.