



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

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
système de santé

Direction de l'amélioration de la performance et de la
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			<input type="checkbox"/> Licensee Copy/Copie du Titulaire <input checked="" type="checkbox"/> Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection April 13, 2011	Inspection No/ d'inspection 2011_121_9549_13Apr125344	Type of Inspection/Genre d'inspection Complaint L-000460	
Licensee/Titulaire Corporation of the County of Grey, 595 9 th Avenue E., Owen Sound, ON N4K 3E3			
Long-Term Care Home/Foyer de soins de longue durée Lee Manor, 875 6 th St., E., Owen Sound, ON N4K 5W5			
Name of Inspector(s)/Nom de l'inspecteur(s) Elizabeth Elvidge #121			
Inspection Summary/Sommaire d'inspection			
The purpose of this inspection was to conduct a complaint inspection relating to responding to written complaints and reporting suspected abuse.			
During the course of the inspection, the inspector spoke with the Administrator.			
During the course of the inspection, the inspector reviewed the date and contents of the e-mail.			
<input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken: 2 WN 1 VPC			

Revised for Publication



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NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit

VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Référance au Directeur

CO – Compliance Order/Ordre de conformité

WAO – Work and Activity Order/Ordre de travail et d'activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.24(1)(2)

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:

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.

Findings:

An e-mail was sent to the Assistant Director of Care at Lee Manor on Feb. 2, 2011 contained examples of alleged abuse.

No Critical Incident was completed and submitted to the MOHLTC by the Home.

Inspector ID #: 121

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with reporting of the suspicion of abuse to a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.101(1)(1)

Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.



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Findings:

An e-mail sent by the [REDACTED] of a resident to the Assistant Director of Care at Lee Manor on Feb. 2, 2011 contained concerns/issues. This e-mail was not responded to in writing.

Inspector ID #:	121
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Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

Title:	Date:	Date of Report: (if different from date(s) of inspection). April 13, 2011
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