

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central West Service Area Office**  
609 Kumpf Drive, Suite 105  
Waterloo, ON, N2V 1K8  
Telephone: (888) 432-7901  
central.west.sao@ontario.ca

<b>Original Public Report</b>	
<b>Report Issue Date:</b> October 28, 2022	
<b>Inspection Number:</b> 2022-1566-0002	
<b>Inspection Type:</b> Complaint Critical Incident System	
<b>Licensee:</b> Corporation of the County of Grey	
<b>Long Term Care Home and City:</b> Lee Manor Home, Owen Sound	
<b>Lead Inspector</b> Katy Harrison (766)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Gabiella Del Principe (741734)	

<b>INSPECTION SUMMARY</b>
<p>The Inspection occurred on the following date(s): October 17-21, 2022</p> <p>The following intake(s) were inspected during this Complaint inspection: - Intake #00005022 - complaint related to multiple care concerns</p> <p>The following intake(s) were inspected during this Critical Incident System (CIS) inspection: - Intake #00005601, related to medications</p>

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

- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Admission, Absences and Discharge

**Ministry of Long-Term Care**

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

**Inspection Report Under the  
Fixing Long-Term Care Act, 2021**

**Central West Service Area Office**

609 Kumpf Drive, Suite 105  
Waterloo, ON, N2V 1K8  
Telephone: (888) 432-7901  
central.west.sao@ontario.ca

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Failure to follow plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that staff followed the plan of care, specifically related to the administration of medications to Resident #001.

#### **Rationale and Summary**

On a specified date, Registered Nurse (RN) #102 administered medications to resident #001 not according to their plan of care. RN #102 confirmed this in an interview.

The Physician assessed the resident the next day and determined that there was no injury to the resident. When asked, the resident stated that it was a one-off incident.

Resident #001 could have been harmed when their medication was not administered as per their plan of care.

**Sources:** Care plan, progress notes, and interviews with Registered Nurse #102, other staff, and Resident #001.

(766)