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

Central West District
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Original Public Report

Report Issue Date: April 24, 2024	
Inspection Number: 2024-1566-0002	
Inspection Type: Critical Incident	
Licensee: Corporation of the County of Grey	
Long Term Care Home and City: Lee Manor Home, Owen Sound	
Lead Inspector Katy Harrison (766)	Inspector Digital Signature Kathryn Harrison Digitally signed by Kathryn Harrison Date: 2024.04.25 08:33:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9-11, 15-18, 2024

The following intake(s) were inspected:

- Intake: #00108612, related to infection prevention and control
- Intake: #00111619, related to prevention of abuse and neglect
- Intake: #00109573, related to falls. The following intake was completed in this inspection: Intake #00109203.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Ontario Regulation 246/22, 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident; (mauvais traitements d'ordre physique)

Rationale and Summary

A resident entered another resident's room and grabbed them by the arm which resulted in one of them sustaining an injury.

Failure to protect the resident from abuse resulted in physical harm and injuries.

Sources: Resident's clinical records, and interview with a RPN (Registered Practical

Nurse). [766]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246 / 22, s. 54 (2); O. Reg. 66 / 23, s. 11.

The licensee failed to ensure that when a resident fell, they were assessed and that a post fall assessment was conducted using a clinically appropriate assessment instrument was used.

Rationale and Summary

When a resident was unable to weight bear, they were lowered to the ground by two PSW's.

A PSW said the resident showed no sign of injury or pain, so they did not report the incident to the nurse immediately. The PSW's got the resident up off the floor using a mechanical lift and continued with care.

Several days later a RPN assessed the resident, the resident was exhibiting signs of pain at that time. They said the resident fell on a previous shift, they were lowered to the ground, that was considered a change of level and was a witnessed fall.

An x-ray was completed that showed the resident had sustained an injury.

The Executive Director confirmed the resident fell and no post fall assessment was completed.

The homes failure to complete a post fall assessment when the resident fell could have prevented early identification and treatment of any potential concerns.

Sources: Review of clinical records, interview with a PSW (Personnel Support Worker) and other staff. [766]