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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: May 9, 2025

Inspection Number: 2025-1566-0002

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Grey

Long Term Care Home and City: Lee Manor Home, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 5-9, 2025

The following intake(s) were inspected:

- Intake #00139105 and intake #00140226 were related to falls prevention and management;
- Intake #00142838 was related to abuse and neglect;
- Intake #00141207, intake #00141654, intake #00141774, intake #00141782, intake #00141898, intake #00144347, intake #00144904, and intake #00145090 were all related to infection prevention and control (IPAC).

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: Duty to protect

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 failed to protect a resident from physical abuse by a co-resident.

The resident sustained an injury as a result of a physical altercation with the co-resident.

Sources: Resident's clinical records, and Interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that an incident of abuse was immediately reported to the Director when a resident sustained injuries as result of a altercation with a co-resident. The incident was not reported to the Director until several days

later, preventing the Director from immediately responding to the incident if required.

Sources: Critical incident report, and interviews with staff.