

# 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: July 9, 2025

**Inspection Number:** 2025-1566-0003

**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): July 2-4, 7-9, 2025

The following intake(s) were inspected:

- Intake #00147686, intake #00149325, intake #00150077, and intake #00151413 were related to infection prevention and control;
- Intake #00147797 was related to prevention of abuse and neglect; and
- Intake #00149314 was related to medication management.

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

Medication Management Infection Prevention and Control Prevention of Abuse and Neglect

## **INSPECTION RESULTS**



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### **WRITTEN NOTIFICATION: Infection Prevention and Control**

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

A staff member was observed not wearing part of the the required personal protective equipment (PPE) in a resident's room that had additional precautions in place as indicated on the signage outside their room. In addition, a PSW was observed donning PPE in the incorrect sequence entering a resident's room with additional precautions in place.

**Sources:** Observations, interview with IPAC lead, and Additional Precautions policy.

### **WRITTEN NOTIFICATION: Police Notification**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).



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A Critical Incident System (CI) Report was submitted related to alleged sexual abuse of a resident. The DOC said that the police had not been notified following the incident by the manager on call.

**Sources:** Ministry of Long Term Care Infoline report, CI report, and interview with staff.