

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: December 10, 2025
Inspection Number: 2025-1566-0004
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): November 26, 2025 and December 1-5, 9 and 10, 2025.

The inspection occurred offsite on the following date(s): November 27, 28, 2025 and December 4, 2025.

The following intake(s) were inspected:

- Intake #00158482 and Intake #00160738 related to falls prevention and management
- Intake #00159515 related to an unexpected death of a resident
- Intake #00159929 and Intake #00160074 related to allegations of neglect
- Intake: #00162603, Intake #00163620, Intake #00163891 and Intake #00164142 related to respiratory outbreaks

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

- Skin and Wound Prevention and Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect

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Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Contenance care and bowel management

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

Contenance care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

On an identified date, a resident was not provided with assistance to change their continence care product to keep them clean, dry and comfortable.

Sources: Resident clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

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

Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

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(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

A staff member delivered a meal tray to a resident's room and left it without notifying the resident. The resident did not eat their meal until later when it was reported that the tray was found in their room.

During the inspection the resident was observed to receive a meal tray. Staff walked past the room however did not enter the room to check on the resident.

The home's tray service policy was not followed. The policy requires staff to set up trays and monitor residents while eating in their rooms.

Sources: Resident clinical records, observation, Critical Incident Report, the home's investigation notes, interview with staff and the home's Tray Service policy.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(b) the date the complaint was received;

During record review, there was no documentation identifying the specific date the concern was raised. The Critical Incident Report submitted to the Ministry of Long-Term Care referenced "yesterday" instead of an exact date when the concern was

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voiced.

Sources: Resident clinical records, Critical Incident Report, and the home's investigation notes.

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (5)

Dealing with complaints

s. 108 (5) Where a licensee is required to immediately forward a complaint under clause 26 (1) (c) of the Act, it shall forward it in a form and manner acceptable to the Director, and,

(a) during the Ministry's normal business hours, to the Director or the Director's delegate; or

(b) outside normal business hours, using the Ministry's after hours emergency contact method.

A concern regarding possible neglect of a resident was received by the home. The complaint was not immediately forwarded to the Director as required.

Sources: Resident clinical records, interview with staff and home's investigation notes.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

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s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

On an identified date, a resident was not administered their medications as specified by the prescriber.

Sources: Resident clinical records, Critical Incident Report, the home's investigation notes, and an interview with staff.