

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:** March 13, 2026

**Inspection Number:** 2026-1566-0001

**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 dates: March 3-6, 9-13, 2026.

The following intakes were inspected:

- Intake #00165788: prevention of abuse and neglect
- Intake #00167029: falls prevention and management
- Intake #00168801: improper care of a resident
- Intake #00168859: resident care and support services

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

- Resident Care and Support Services
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Transferring and positioning techniques

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

**Non-compliance with: O. Reg. 246/22, s. 40**

Transferring and positioning techniques

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s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specific date, a resident fell and was lifted by staff up off the floor when a mechanical lift should have been utilized.

Sources: a resident's clinical health records, interviews with the home's staff, video surveillance, the home's policy entitled "Falls Prevention and Management" (last reviewed August 2025).

### **WRITTEN NOTIFICATION: Dress**

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

**Non-compliance with: O. Reg. 246/22, s. 44**

Dress

s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

On a specific date, a staff member was observed forcibly assisting a resident to dress and did not follow their plan of care.

Sources: a resident's Kardex, and interviews with staff.

### **WRITTEN NOTIFICATION: Communication methods**

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

**Non-compliance with: O. Reg. 246/22, s. 47**

Communication methods

s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

On a specific date, a Personal Support Worker (PSW) gave a resident rapid instructions, and did not allow the resident time to respond. This did not follow the

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resident's plan of care.

Sources: a resident's Kardex and interviews with staff.

### **WRITTEN NOTIFICATION: Skin and wound care**

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

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,  
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,  
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

On a specific date, a resident sustained a skin tear. Weekly skin assessments were not completed for the skin tear.

Sources: a resident's clinical health records and interviews with staff.



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

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