

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2021	2020_836766_0023	022555-20, 023057-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East Owen Sound ON N4K 3E3

Long-Term Care Home/Foyer de soins de longue durée

Lee Manor Home
875 Sixth Street East Owen Sound ON N4K 5W5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATY HARRISON (766)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 9,10, 14, 15, 2020.

The following intakes were inspected:

Log #023057-20 related to Abuse and Neglect;

Log #022555-20 follow-up to CO #001 from inspection #2020_739694_0024 related to resident plan of care, specifically, safe lift and transfer interventions; providing assistance required for dressing and bathing; retraining of all staff on safe lift and transfers.

During the course of the inspection, the inspector(s) spoke with the ED, DOC, PSW Supervisor, RPN and a PSW.

The Inspector also observed the provision of resident care, staff-resident interactions, reviewed Resident's clinical records, the Homes investigation notes, Critical Incident reports and completed staff interviews.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2020_739694_0024		766

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Légende

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24.
Reporting certain matters to Director**

Specifically failed to comply with the following:

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

An allegation was made by a PSW that another PSW had spoken inappropriately to a resident, and that on another occasion the same PSW may have caused physical injury to the resident. Approximately two months later these allegations were disclosed to the ED who initiated an investigation. Given the delay in staff reporting, the alleged incidents were not reported to the Director until approximately two months after they occurred.

Not reporting the suspected abuse immediately put the resident and other residents at further risk of harm from the PSW.

Sources: Observations; Resident's Clinical Records; Home's investigation notes; Critical Incident Reports; Interviews with the PSW Supervisor and ED. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that anyone who has reasonable grounds to suspect that 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 immediately reports the suspicion and the information upon which it is based to the Director. S.24 (1), to be implemented voluntarily.

Issued on this 5th day of January, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.