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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 7, 2024
Original Report Issue Date: February 6, 2024
Inspection Number: 2024-1566-0001 (A1)
Inspection Type: Critical Incident
Licensee: Corporation of the County of Grey
Long Term Care Home and City: Lee Manor Home, Owen Sound

Amended By JanetM Evans (659)	**Inspector who Amended Digital Signature** Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.02.07 12:00:56 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: correct the original report issue date to February 6, 2024.

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Lead Inspector JanetM Evans (659)	**Additional Inspector(s)**
Amended By JanetM Evans (659)	**Inspector who Amended Digital Signature** Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.02.07 12:01:33 -05'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29 -31, 2024 and February 1, 2024

The following intake(s) were inspected:

- Intake: #00101397 - Related to a resident fall with injury
- Intake: #00105605 - Related to an outbreak

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

Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that care set out for a resident was provided as specified in the plan.

Rationale and Summary:
A resident was found on the floor of their room and they had sustained an injury.

An RPN said when they assessed the resident they noted that the fall prevention equipment had not been activated.

Sources: resident's clinical records, interview with RPN
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WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised related to falls prevention and management, when, care set out in the plan had not been effective.

Rationale and Summary:
A resident was assessed as at risk for falls upon their admission. They had three falls within a four month period of time. The third fall resulted in an injury.

The home's fall prevention and management program directed staff to review and update resident care plans post fall and provided recommendations of additional interventions and equipment for consideration for fall prevention.

Their plan of care at admission included the resident's fall prevention equipment and interventions. The interventions for falls prevention and management were not reviewed and revised following the first and second falls.

Failing to update the resident's plan of care with new fall prevention strategies put the resident at risk of injury.

Sources: Resident's clinical records, VII-G-30.10(b) Post Fall Flow Chart ,VII-G-30.10(a) Fall Risk Factors Related Interventions, VII-G-30.10 Falls Prevention-Management GREY COUNTY, interviews with DOC, ADOC and staff.
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