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

Original Public Report

Report Issue Date: November 12, 2024	
Inspection Number: 2024-1566-0004	
Inspection Type: Critical Incident	
Licensee: Corporation of the County of Grey	
Long Term Care Home and City: Lee Manor Home, Owen Sound	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, and November 1, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00120621 was related to transfers,
- Intake #00124325 was related to neglect of residents,
- Intake #00127235 was related to falls,
- Intake #00127321 and Intake #00127813 were related to infection prevention and control.

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

Resident Care and Support Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Fall Prevention and Management

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
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.

The licensee has failed to ensure that a staff member used safe techniques when transferring a resident.

Rationale and Summary
A personal support worker (PSW) attempted to transfer a resident. The resident's transfer status had been changed. During the transfer, the resident fell causing injuries.

The resident's plan of care had recently been updated earlier that day. The PSW confirmed they did not check the care plan prior to transferring the resident, resulting in an unsafe transfer and fall.

Failure to review the resident's care plan prior to providing care resulted in an injury.

Sources: Interview with staff, clinical records, and CI report.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In Accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that residents' falls interventions are followed as per the plan of care.

Rationale and Summary
Two residents were found on the floor. Both residents required hourly safety checks as per their plan of care.

A PSW confirmed they failed to complete hourly safety checks for the residents, and the residents were found on the floor by another staff. The home was unable to determine how long the resident's had been lying on the floor. The PSW did not follow the interventions on the care plan.

The bed alarm was not on properly and therefore the alarm did not sound when the one resident exited the bed.

Failure to follow interventions on the care plan put the residents at risk of harm.

Sources: Interviews with staff, resident clinical records, LTCH's investigation notes, CI Report, LTCH's Falls Prevention & Management policy.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that any directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health with respect to infection prevention and control was followed.

Specifically, the Recommendations for Outbreak Prevention in Institutions and Congregate Living Setting - April 19, 2024, indicates that during a COVID-19 outbreak the infection prevention and control (IPAC) lead/designate should conduct weekly IPAC audits for the duration of the outbreak.

Rationale and Summary
The IPAC lead confirmed that the IPAC lead/designate completed two self-assessment audits for the LTCH during an outbreak.

During the outbreak, the home completed the self-assessment audit tool on the day the outbreak was declared and the following week, but not during the final week of the outbreak as per guidelines.

Failure to complete the recommended IPAC audits could result in the spread of infection in the home.

Sources: Record review, Recommendations for Outbreak Prevention in Institutions and Congregate Living Setting - April 19, 2024, and interview with staff.