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
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: January 29, 2025

Inspection Number: 2025-1566-0001

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 Written Notification was modified to make administrative changes.

The inspection occurred onsite on the following date(s): January 22-23, 27-29, 2025
The inspection occurred offsite on the following date(s): January 24, 2025

The following intake(s) were inspected:

- Intake: #00129325 – related to infection prevention and control
- Intake: #00135700 – related to infection prevention and control
- Intake: #00137519 – related to abuse and neglect
- Intake: #00137532 – related to abuse and neglect
- Intake #00138074 – related to medication management
- Intake: #00136041 – related to falls. The following intakes were bundled and completed in this inspection: Intake #00132489, Intake #00133719, both were related to falls.

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

Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Ontario Regulation 246/22, 2 (1) (b) defines sexual abuse as,
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitements d'ordre sexuel")

The licensee has failed to ensure that the required interventions were completed for a resident, which resulted in the abuse of another resident. Failure to complete the required interventions for the resident resulted in a second incident of abuse to the same resident.

Sources: Resident's clinical records, CIS reports, interview with Registered Practical Nurse (RPN), Director of Care (DOC)