

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

London District

130 Dufferin Avenue, 4th Floor London, ON, N6A 5R2 Telephone: (800) 663-3775

	Original Public Report
Report Issue Date: September 16, 2024	
Inspection Number: 2024-1622-0004	
Inspection Type:	
Critical Incident	
Licensee: The Corporation of the County of Middlesex	
Long Term Care Home and City: Strathmere Lodge, Strathroy	
Lead Inspector	Inspector Digital Signature
Clare Hoevenaars (000834)	
Additional Inspector(s)	
Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date: September 12, 2024

The following intake was inspected:

• Intake: #00123153/Critical Incident (CI) #M627-000015-24 - related to infection prevention and control

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

Infection Prevention and Control



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INSPECTION RESULTS

WRITTEN NOTIFICATION: CMOH and MOH

NC #001 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 has failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health Effective: April 2024 was followed in the home. In accordance with these recommendations the Licensee was required to ensure that Alcohol-based hand rubs (ABHR) must not be expired.

During an observation, ABHR was observed to be expired in a resident room.

In an interview, IPAC lead acknowledged it was the expectation that the expired ABHR be replaced.

There was risk to the residents and staff of potential transmission of microorganisms when the home used expired ABHR product.

Sources: observation in resident room and interview with IPAC lead.