



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

London Service Area Office
130 Dufferin Avenue 4th floor
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Telephone: (519) 873-1200
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130 avenue Dufferin 4ème étage
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2015	2015_260521_0012	001752-15	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF MIDDLESEX
c/o Strathmere Lodge 599 Albert Street, P.O. Box 5000 STRATHROY ON N7G 3J3

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

STRATHMERE LODGE
599 Albert Street Box 5000 STRATHROY ON N7G 3J3

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

REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 26, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nursing Coordinator, communication via text with the Director of Resident Care, 1 Registered Nurse, 1 Personal Support Worker and 1 Family member. The inspector conducted a tour of 2 resident areas, observed residents and the care provided to them. Clinical records for identified residents were reviewed. The inspector reviewed records, policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

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

5 WN(s)

4 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that residents are protected from abuse by anyone.

A resident was found on the floor. The internal investigation deemed the resident had been put on the floor by another resident.

A separate incident occurred whereby the same resident was found injured while in their bed during an afternoon nap. The internal investigation concluded the resident had sustained the injury from another resident.

The Nursing Coordinator confirmed the resident had been a victim of abuse and it was the licensee's expectation that residents were to be protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident; 2007, c. 8, s. 6 (1).

(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).

(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

An electronic record review of a resident revealed the resident was to be bathed twice a week in the pm.

An interview with a family member revealed the family had concerns that the resident was not bathed twice per week.

The electronic shared schedule file revealed the resident was to be bathed twice a week in the am.

The care plan revealed the resident was to be bathed once per week.

A record review revealed the resident missed a bath.

The Nursing Coordinator confirmed the plan of care failed to set out clear direction and it was the licensee's expectation that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home



Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

Observations revealed a spa door unlocked and propped open by a garbage bin. Inside the spa were hazardous chemicals (cleaning products) and prescription shampoos that were to be kept inaccessible to residents.

An interview with a Personal Support Worker revealed the homes expectation was that the door to the spa was to be locked when the room was not supervised by staff. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance



Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy ADA 007 Abuse January 10, 2011 was complied with.

A review of the clinical records revealed a resident was found on the floor. An internal investigation by the long term care home concluded another resident had put the resident on the floor.

Policy ADA 007 Abuse January 10, 2011 page 7/10 2. states the RN/RPN will assist the resident in the completion of the incident form as necessary.

An interview with the Nursing Coordinator revealed the registered staff failed to complete an incident form and the Director of Resident Care had failed to make a report to the Director. [s. 20. (1)]

2. Resident was found injured in their bed.

Policy ADA 007 Abuse January 10, 2011 page 5/10 "Immediately upon becoming aware of the abuse incident, the Director of Resident Care or designate will ensure that the Ministry of Health and Long Term Care is notified by initiating the on-line Mandatory Critical Incident Report as required".

An interview with the Nursing Coordinator revealed the Director of Resident Care failed to make reports to the Director.

The Nursing Coordinator confirmed it was the expectation that the policy was complied with. [s. 20. (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 the written policy ADA 007 Abuse January 10, 2011 was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

Every licensee of a long-term care home shall ensure that,

- (a) a written record is created and maintained for each resident of the home; and**
- (b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.**

Findings/Faits saillants :

1. The Licensee failed to ensure that a written record is created and maintained for each resident;

A record review revealed a Resident was put to bed at a specific time and two hours later was found injured.

The care plan for the resident revealed the resident would be monitored hourly.

An interview with the Nursing Coordinator revealed the records for monitoring residents hourly were destroyed and no longer part of the resident record. [s. 231. (a)]

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 a written record is created and maintained for each of the home, to be implemented voluntarily.



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Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 14th day of April, 2015

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

Original report signed by the inspector.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : REBECCA DEWITTE (521)

Inspection No. /

No de l'inspection : 2015_260521_0012

Log No. /

Registre no: 001752-15

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : Apr 8, 2015

Licensee /

Titulaire de permis :

THE CORPORATION OF THE COUNTY OF
MIDDLESEX

c/o Strathmere Lodge, 599 Albert Street, P.O. Box 5000,
STRATHROY, ON, N7G-3J3

LTC Home /

Foyer de SLD :

STRATHMERE LODGE

599 Albert Street, Box 5000, STRATHROY, ON,
N7G-3J3

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : TONY ORVIDAS



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

To THE CORPORATION OF THE COUNTY OF MIDDLESEX, you are hereby
required to comply with the following order(s) by the date(s) set out below:



Order # /
Ordre no : 001 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee shall ensure the residents of the long term care home are protected from abuse by anyone.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents are protected from abuse by anyone.

A resident was found on the floor. The internal investigation deemed the resident had been put on the floor by another resident.

A separate incident occurred whereby the same resident was found injured while in their bed during an afternoon nap. The internal investigation concluded the resident had sustained the injury from another resident.

The Nursing Coordinator confirmed the resident had been a victim of abuse and it was the licensee's expectation that residents were to be protected from abuse by anyone. [s. 19. (1)]

(521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
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de l'article 154 de la *Loi de 2007 sur les foyers
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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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section 154 of the *Long-Term Care
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des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of April, 2015

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** Rebecca Dewitte

**Service Area Office /
Bureau régional de services :** London Service Area Office