

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

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

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 14, 2021	2021_777731_0023	007974-21, 010137- 21, 013892-21, 013968-21	Critical Incident System

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**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

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

Strathmere Lodge  
599 Albert Street Box 5000 Strathroy ON N7G 3J3

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

KRISTEN MURRAY (731), MEAGAN MCGREGOR (721)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 23, 24, 27, 28, 29, and October 1, 2021.**

**The following Critical Incident intakes were completed within this inspection:**

**Related to responsive behaviours:**

**Critical Incident Log #007974-21 / CI M627-000011-21**

**Related to falls prevention:**

**Critical Incident Log #010137-21 / CI M627-000012-21**

**Related to an incident resulting in injury:**

**Critical Incident Log #013892-21 / CI M627-000017-21**

**Related to medication administration:**

**Critical Incident Log #013968-21 / CI M627-000018-21**

**An IPAC inspection was also completed at the time of this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a Housekeeper, and residents.**

**The inspectors also observed resident rooms and common areas, observed snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the home's investigation notes, and reviewed medication incidents.**

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

**Falls Prevention  
Infection Prevention and Control  
Medication  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

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

**1 WN(s)**

**1 VPC(s)**

**0 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>Légende</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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the policies related to falls management and head injury assessment were complied with, for two residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policies and procedures "Resident Accident/Injury - Reporting Policy", last reviewed June 2019 and "Resident Accident/Incident - Head Injury Assessment Routine", last reviewed February 2018.

The resident injury reporting policy, and head injury routine (HIR) assessment policy required staff to complete a HIR assessment for every resident who had a fall with head injury and every resident who had an unwitnessed fall.

A resident sustained multiple unwitnessed falls and the HIR had sections of the assessments that were incomplete and stated the resident was sleeping.

A resident sustained an unwitnessed fall and a HIR assessment was initiated. One of the assessment sections was not completed, which indicated the resident was sleeping.

The Director of Resident Care stated that the expectation in the home was that staff completed the HIR for residents who had sustained unwitnessed falls and the staff should have attempted to wake a resident if they were sleeping to complete the sections of the HIR. There was minimal risk to the residents, related to the HIR assessments not being completed.

Sources: "Resident Accident/Injury – Reporting Policy", number NMR002 (last reviewed 2019/06/07), "Resident Accident/Incident - Head Injury Assessment Routine", number NMR004 (last reviewed 2018/02/27); two residents' progress notes and HIR assessments; and interviews with the DRC and other staff. [s. 8. (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 the policies related to falls management and head injury assessment are complied with, to be implemented voluntarily.***

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Issued on this 15th day of October, 2021

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

**Original report signed by the inspector.**