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

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

Public Report

Report Issue Date: September 10, 2025
Inspection Number: 2025-1622-0005
Inspection Type: Critical Incident
Licensee: The Corporation of the County of Middlesex
Long Term Care Home and City: Strathmere Lodge, Strathroy

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9, 10, 2025

The following intake(s) were inspected:
-Intake 00155184 / CIS #M627-000011-25 related to falls prevention and management.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

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 transferring techniques when assisting a resident.

A resident required assistance from staff for transfers. The resident was left unattended and had a fall which resulted in injury.

The Director of Care (DOC) confirmed that the resident should not have been left unattended.

Sources: Critical Incident System (CIS) report; resident clinical records; staff interviews and the home's safe lift and transfer policy.