Committee of the Whole

Meeting Date:	**May 25, 2021**
Submitted By:	**Brent Kerwin, Administrator, Strathmere Lodge**
SUBJECT:	**MINISTRY OF LONG TERM CARE COMPLIANCE INSPECTOR VISIT**

BACKGROUND:

The Lodge received the Public Copy of its "Critical Incident System" inspection report on May 11, 2021 (attached).

On May 6th and 7th, one (1) Compliance Inspector from the Ministry of Long Term Care ("The Ministry") visited The Lodge in order to conduct an inspection of a single "Critical Incident", further to The Lodge's Critical Incident Report submitted to the Ministry on January 29, 2021. The Inspector also conducted an Infection Prevention and Control (IPAC) inspection while on site.

As per provincial Long Term Care Homes legislation, homes must file Critical Incident reports with The Ministry for various incidents, including: a report of abuse; a missing resident; a missing or unaccounted for controlled substance (e.g., narcotic); an unexpected or sudden death; or an incident causing injury to a resident (e.g., fall with fracture) requiring a hospital visit and resulting in a significant health status change. The Ministry will review/investigate such incident reports.

Inspection reports are posted at The Lodge as required by provincial Long Term Care Homes legislation. Inspection reports are reviewed at meetings of The Lodge's Residents' Council and Family Council. The Ministry posts home inspection reports on its provincial Public Reporting website.

In addition to doing Critical Incident Report inspections, Ministry Inspectors also make unannounced visits to long term care homes in order to:

a) Conduct Annual Inspections;
b) Investigate complaints (received on the provincial toll-free complaint line); and
c) Do follow-up inspections on concerns identified during previous inspections.

ANALYSIS:

In January, The Lodge reported a resident fall incident resulting in a hip fracture. This is reportable to The Ministry.

The Compliance Inspector completed her review of the reported incident on May 7, 2021, issuing her report with no findings of non-compliance to provincial Long Term Care Homes legislation. This would indicate that the Inspector was satisfied with the applicable resident's individualized care plan, including the interventions that were in place to minimize the possibility of a fall, and the interventions put in place to manage the resident's post fall recovery.

Attachment

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 11, 2021	2021_777731_0011	001813-21	Critical Incident System

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

KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6 and 7, 2021.

The following Critical Incident intake was completed within this inspection:

Critical Incident Log #001813-21 / CI M627-000002-21 related to falls prevention.

An IPAC inspection was also completed as part of this inspection.

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

The inspector also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents and reviewed the home's investigation documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were not issued.
- **0 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Issued on this 11th day of May, 2021

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

Original report signed by the inspector.