

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: November 13, 2025
Inspection Number: 2025-1564-0004
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the County of Lambton
Long Term Care Home and City: Lambton Meadowview Villa, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 10, 12, 13, 2025
The inspection occurred offsite on the following date(s): November 7, 2025
The following intake(s) were inspected:

- Intake: #00161379 - Critical Incident System report # M547-000042-25 related to an outbreak.
- Intake: #00161838 - Related to a complaint alleging abuse and breach of privacy rights.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

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residents are fully respected and promoted:

19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

A residents family members reported to members of the management team of the home, that a person attending the home had shared personal information about the resident with a person outside of the home. The resident and family members shared that they did not consent, or wish for any information to be shared with the person outside of the home. The person attending the home confirmed that they had shared personal information about the resident with a person that should not have received the information. The Administrator acknowledged that the resident's right to privacy had been violated.

Sources: The resident's clinical record, the homes investigation file and interviews with the resident and staff.

WRITTEN NOTIFICATION: Reporting Certain Matters To The Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A residents family members alleged that a resident experienced physical abuse from a person attending the home. Documentation from the investigation file at the home supported that the family members reported the alleged abuse to members of the

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management team. The Administrator acknowledged that they did not submit a Critical Incident System report to the Director.

Sources: A resident's clinical record, the homes investigation file and interviews with the resident and staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically the licensee must;

- A. Educate a specific staff member on the required use of appropriate PPE, donning and doffing. Maintain a written record of all education completed including the content, who facilitated the education, who attended and the date the education was completed.
- B. The IPAC Lead will complete a weekly audit on all the identified staff member in Part A until the order is complied, related to their PPE donning and doffing. Maintain a written record for all audits, including who conducted the audit, who was audited, the location, date, any deficiencies and corrective actions taken.
- C. Provide a written reminder or review with all staff relating to PPE usage. Maintain a written record of how the review material was provided, when and who completed the review.

Grounds

In accordance with Ontario Regulation 246/22, s. 102 (2) b, where the licensee must comply to the standard issued by the Director with respect to IPAC; IPAC Standard for Long-Term Care, last revised September 2023; section 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: d) Proper use of PPE, including appropriate

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selection, application, removal, and disposal.

During an observation a staff member was observed to have entered into a posted Droplet Contact Precaution room with a mask and eye protection on, without completing hand hygiene. While in the room, the staff had provided the resident with a call bell, collected dirty dishes and had opened the residents window. The staff had come within 2-meters of the resident with a confirmed infectious disease.

Sources: Observation, record review and staff interviews.

This order must be complied with by January 30, 2026

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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/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.