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
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Public Report

Report Issue Date: July 25, 2025

Inspection Number: 2025-1151-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Meadow Park (London) Inc.

Long Term Care Home and City: Meadow Park (London), London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17, 18, and 22-25, 2025.
The inspection occurred offsite on the following date(s): July 24, 2025.

The following intake(s) were inspected:

- Intake: #00147028 - Follow-up #01 of Compliance Order (CO) #001 from inspection #2025-1151-0002, FLTCA, 2021, s. 24 (1), duty to protect.
- Intake: #00149093 - Critical Incident (CI) #2643-000026-25 related to falls prevention and management.
- Intake: #00149516 - CI #2643-000028-25 related to alleged neglect.
- Intake: #00151032 - CI #2643-000030-25 related to falls prevention and management.
- Intake: #00151496 - CI #2643-000032-25 related to alleged improper care.

A triage officer was also present during this inspection.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1151-0002 related to FLTCA, 2021, s. 24 (1)

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Falls Prevention and Management

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) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident had the right to proper care and services consistent with their needs. A resident was transferred to their mobility device during morning care and was not transferred back into their bed until after the dinner meal despite multiple requests over that time period. The resident

experienced pain as a result of the incident.

Sources: interviews with the resident, two person support workers (PSWs), review of progress notes, assessments, care plan, and POC documentation.

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that a PSW provided a resident with a required assistive device to safely consume a hot beverage. The resident was injured when the assistive device was not provided.

Sources: record review of Critical Incident (CI) #2643-000032-25, the resident's health care records, and the resident home area's "Master Diet List", and interviews with the resident, a PSW, and the home's Culinary Manager.