

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

Original Public Report

Report Issue Date: June 14, 2023	
Inspection Number: 2023-1564-0003	
Inspection Type: Critical Incident System	
Licensee: The Corporation of the County of Lambton	
Long Term Care Home and City: Lambton Meadowview Villa, Petrolia	
Lead Inspector Terri Daly (115)	Inspector Digital Signature
Additional Inspector(s) Debra Churcher (670) Stacey Sullo (000750) Cassandra Taylor (725)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5, 6, 7 and 8, 2023.

The following intake(s) were inspected:

- Intake: #00002776 - M547-000002-22 related to alleged abuse
- Intake: #00012037 - M547-000034-22 related to responsive behaviours
- Intake: #00012499 - M547-000036-22 related to responsive behaviours
- Intake: #00021070 - M547-000006-23: related to Improper/Incompetent treatment
- Intake: #00086851 - M547-000017-23: related to a fall
- Intake: #00086854 - M547-000018-23: related to alleged neglect

These intakes Intake: #00085690 - M547-000011-23, #00086800 - M547-000016-23, #00017188 - M547-000045-22, #00013949 - M547-000038-22, #00005092 - M547-000025-22, #00006454 - M547-000010-22, #00007157 - M547-000031-22, #00017842 - M547-000003-23, were reviewed with other intakes related to Falls Prevention and Management.

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

- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards
- Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22, s. 12 (1) 1. i.

RATIONALE and SUMMARY:

The licensee of the home failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked.

Inspector #670 noticed that a steel door leading to the outside front entry seating area by the driveway was open and secured open with a bungee cord attached to the door handle and the handrail behind the door on the wall. Immediately, a staff member, saw the inspectors by the door and came over. They indicated that this door should not be opened and they would ensure it was locked and closed. This staff member was asked to follow up and ensure an investigation to determine how and why the door was left open.

When the ministry staff exited the home shortly after, Inspector #115 went to check that the door was secure, and found it was closed but still unlocked. A staff member, attended to the area immediately indicating that they thought the door would lock when closed, that they would call for back up to ensure this time the door was closed and secured.

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Interview with the Environmental Services Supervisor (ESS) indicated that they had completed an investigation after receiving report about the door being open and unlocked, they explained that the elevator repair staff had a key to this door to bring in supplies and equipment into the building to repair a broken elevator, that the contractor had unlocked the door and applied the bungee cord to keep it open.

The ESS explained to the contractors that this was a safety concern and risk for the resident's in the home, that all doors were to be closed and secure at all times.

The ESS explained that the home completed a count of all residents to ensure that no one had eloped during the time the door was left ajar.

A check of the door @1305 hours found that it was closed and locked, and the ESS verified that all resident's were accounted for.

SOURCES:

observations and interviews.

[115]

Date Remedy Implemented: June 7, 2023



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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