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: May 8, 2025

Inspection Number: 2025-1151-0002

Inspection Type:
Complaint
Critical Incident

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): April 28-30, and May 1, 2, and 5-8, 2025.

The following intake(s) were inspected:

- Intake: #00138863 - Critical Incident (CI) #2643-000001-25 related to a resident fall with injury
- Intake: #00140871 - CI #2643-000007-25 related to a missing resident
- Intake: #00141034 - CI #2643-000008-25 related to a hypoglycemic event
- Intake: #00142037 - CI #2643-000009-25 related to a resident fall with injury
- Intake: #00143655 - CI #2643-000011-25 related to an allegation of sexual abuse of a resident by a staff member
- Intake: #00144203 - CI #2643-000013-25 related to a response to a care complaint
- Intake: #00144557 - CI #2643-000016-25 related to a response to a care complaint
- Intake: #00145648 - CI #2643-000017-25 related to an allegation of improper care of a resident
- Intake: #00143554 - complaint related to staffing

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to ensure when a resident demonstrated responsive behaviours that behavioural triggers were identified, where possible.

Sources: review of the resident's electronic medical records and behaviour intervention plan, and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure when a resident continued to express responsive behaviours that they were reassessed and their responses to interventions were documented to identify the effectiveness of the interventions. This failure resulted in the identified changes to the resident's behavior plan of care not being completed, which meant the plan was not meeting their needs

Sources: review of the resident's electronic medical records and behavioural intervention plan, and interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Update the home's applicable policy.
B) Update the home's orientation training content.
C) Provide retraining to all staff on 1) the updates to the home's policy required in part A of this order, and 2) the updates to the home's orientation training required in part B of this order. A record of the training is to be kept in the home until this order is complied, and will include 1) the dates of the training, 2) the content of the training, and 3) the names of the staff who attended the training.

Grounds

The licensee has failed to protect a resident from sexual abuse by a staff member.

Section 2 of Ontario Regulation 246/22 defines sexual abuse as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member".

The actions of the staff member negatively impacted the resident.

Sources: the home's investigation notes into CI #2643-000011-25, the home's policies, the staff member's training records and employee file, and the resident's plan of care, and interviews with the resident, the staff member, a local police officer, and multiple other staff members.

This order must be complied with by July 4, 2025

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

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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.