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: October 29, 2025
Inspection Number: 2025-1520-0007
Inspection Type:
Critical Incident

Licensee: St. Joseph's Health Care, London
Long Term Care Home and City: Mount Hope Centre for Long Term Care, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 20-23, and 27-29, 2025

The following intake(s) were inspected:

- Intake: #00156498/C596-000148-25 Fall of resident sustaining an injury.
- Intake: #00158288/C596-000168-25 Allegations of abuse of a resident- alleges rough care.
- Intake: #00158643/C596-000172-25 Environmental hazard- Flood.
- Intake: #00159190/C596-000179-25 Improper care related to medication management.

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

Housekeeping, Laundry and Maintenance Services
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that medications were administered to a resident in accordance with the prescriber's directions for use. The home received a letter from the prescriber, identifying medication administration concerns. This triggered the home's internal investigation and a CIS report related to medication errors, resulting in this inspection. The following medication errors were confirmed:

A) The resident had a routine order for a medication twice a day. In addition to the routine dosing, an additional dose of that medication was required conditional on the fasting body weight. On two dates in September, 2025 the weight was not available and two morning doses were not provided.

B) If the resident's body weight was greater than the ordered target the resident would require a dose of a second medication.
On three dates in September, 2025, the resident's weight was above the ordered target, which required a dose of the second medication, but it was not administered.

Sources: Clinical records for a resident, Patient Safety: Medication errors report for the month of September 2025, Complaint letter from a health care prescriber, Interviews with family and staff.