

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: July 30, 2025

Inspection Number: 2025-1031-0001

Inspection Type:

Complaint

Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation

Long Term Care Home and City: Tilbury Manor Nursing Home, Tilbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00153025 - PC-2025-0000298 related to a complaint surrounding medication administration.

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

Medication Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Medication Administration

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 a medication was administered to a resident in accordance with the directions for use specified by the prescriber. There were multiple missed doses of the medication.

Sources: resident's medical record, investigation notes, and interviews.

WRITTEN NOTIFICATION: Documentation

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

Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records

s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's written record was kept up to date at all times. There were multiple missed doses of a medication. It was documented as being administered although it was not.

Sources: resident's medical record and interviews.