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

Original Public Report

Report Issue Date: June 17, 2024
Inspection Number: 2024-1623-0002
Inspection Type: Complaint
Licensee: The Corporation of the City of St. Thomas
Long Term Care Home and City: Valleyview Home, St Thomas

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.06.17 12:41:33 -04'00'

Additional Inspector(s)
Dante De Benedictis (000818)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00113588, complaint related to specific resident care concerns.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Recreational and Social Activities

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.

The licensee has failed to ensure drugs for a resident were administered to the resident in accordance with the directions for use specified by the prescriber.

Rational and summary:
The Ministry of Long-term Care received a complaint related to specific resident care concerns.

A review for the resident's Electronic Medication Administration Records for a specific month showed a medication routine order that would be administered as needed. A further record review and interview with the Director of Care showed the specific medications were not administered as per the medication orders.

The Director of Care said the resident did not receive their medications as prescribed by the physician.

There was a risk to the resident when they did not receive their medications as prescribed.

Sources: record reviews and staff interviews. [000818]