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

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Public Report

Report Issue Date: February 11, 2025
Inspection Number: 2025-1623-0001
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the City of St. Thomas
Long Term Care Home and City: Valleyview Home, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 10, 11th, 2025

The following intake(s) were inspected:

- Intake: #00135135/Critical Incident (CI)# M628-000027-24 related to a fall
- Intake: #00138284/CI #M628-000002-25 related to a medication error
- Intake: #00138357 complaint related to resident care

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
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)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure oral care set out in the resident's plan of care was based on their preference.

The plan of care did not reflect the resident's oral care preference. This issue was addressed, and the plan of care was updated to include the specified times for oral care as requested by the residents Power of Attorney (POA).

Sources: residents plan of care, staff interviews

Date Remedy Implemented: February 10, 2025

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The licensee failed to ensure their policy "New Medication Orders" was followed when staff failed to verify that a medication order had been properly input to the resident's medical administration record (MAR), causing the resident to receive the medication beyond the prescriber's specified stop date.

Sources: resident's medical chart and MAR, LTCH investigation notes, LTC policy and staff interviews.

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 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 failed to ensure that staff administered a resident's medication according to the prescriber's specified directions

Sources: resident medical chart and MAR, LTCH investigation notes, staff interviews