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: August 21, 2025
Inspection Number: 2025-1623-0004
Inspection Type:
Critical Incident
Follow up

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): August 12, 13, 14, 15, 18, 20, 21, 2025.

The following intake(s) were inspected:
Intake: #00147991 – Critical Incident system (CIS) report #M628-000010-25, related to the falls management program.
Intake: #00148480 – CIS #M628-000011-25, also related to the falls management program.
Intake: #00148649 - CIS #M628-000012-25, related to allegations of staff to resident neglect.
Intake: #00149043 - Follow-up for Compliance Order (CO) #001, related to Nutritional care and hydration programs.
Intake: #00149044 - Follow-up for CO #002, related to staff training.
Intake: #00149045 - Follow-up for CO #003, also related to staff training.
Intake: #00149046 - Follow-up for CO #004, also related to staff training.
Intake: #00149769 – CIS #M628-000013-25, related to allegations of resident-to-resident abuse.
Intake: #00151845 – CIS #M628-000016-25, related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1623-0003 related to FLTCA, 2021, s. 82 (2)
Order #003 from Inspection #2025-1623-0003 related to FLTCA, 2021, s. 82 (4)
Order #004 from Inspection #2025-1623-0003 related to FLTCA, 2021, s. 82 (7)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2025-1623-0003 related to O. Reg. 246/22, s. 74 (2) (a)

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

Medication Management
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The home was ordered to complete a review of the home's menu cycle to ensure specific texture menu items met the home's policy and to maintain a log of the home's review and any menu items which did not meet policy requirements.

A discussion with the home supported neither the menu in place at the time of the order or the current menu were reviewed. Nor was there a log maintained to record any menu items, that did not meet the home's policy specifications.

Furthermore, the home was ordered to provide training for any staff responsible for monitoring food textures and to keep a log of the training including: the name of the person receiving the training, the date the training occurred, and a signature of the trainee indicating that they understand the process.

The home policy states that all dietary staff are responsible for ensuring that prepared texturized food items, including ground and pureed diets, consistently meet the correct specifications.

A discussion with the home supported, that all staff would be included in the training; however not all dietary staff completed the training.

Sources: interview with Food Services Manager and Nutritional Management Services Support, review of home policies and training sign-off, kitchen observation.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
There was no Written Notification for FLTCA, 2021, s. 104 (4) issued in the past 36 months.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee failed to ensure that a resident's right to freedom from neglect was fully respected and promoted when a resident who could not be left alone was left alone by staff for an extended period of time.

Sources: Resident clinical records and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that a resident's plan of care set out clear directions for staff and others when a resident who could not be left unattended was left

unattended for an extended period of time.

Sources: Resident's clinical records, and an interview with the DOC

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan. Furthermore, staff falsely documented they provided the care, when in actuality the staff had not.

Sources: Resident clinical records, Home's Investigation Notes, and an interview with the DOC.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that the falls prevention and management program was implemented when a resident had a fall, and a scheduled assessment was not started or completed.

In accordance with O.Reg. 242/22 s. 11(1)(b) where this Regulation required the licensee to put in place a falls program. The licensee was required to ensure that all parts of the program, including the completion of scheduled assessments were complied with.

Sources: Resident clinical records, interviews with staff and management.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 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 appropriate actions were taken to respond to a resident's responsive behaviour needs, following the demonstration of responsive behaviours involving another.

Sources: CIS #18-25, resident clinical records, and interviews with staff and management.

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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.