

**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:** November 4, 2025

**Inspection Number:** 2025-1623-0005

**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): October 27, 28, 29, 30, 31, and November 3, and 4, 2025.

The following intake(s) were inspected:

- Intake #00155956 was a second follow-up inspection to Compliance Order (CO) #001 from inspection 2025-1623-0004 related to nutritional care and hydration programs. A re-inspection fee of \$500 was applied.
- Intake #00159365 / Critical Incident (CI) M628-000021-25 was related to an infectious disease outbreak.
- Intake #00159739 / CI M628-000023-25 was related to an incident of resident to resident abuse.

**Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance:

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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:

- Food, Nutrition and Hydration
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Sexual abuse as defined by the regulations means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A resident was found to be engaging in non-consensual touching of a sexual nature with another resident by a Personal Support Worker (PSW). The Director of Care (DOC) and two registered staff familiar with the residents, confirmed that neither resident had been assessed for their ability to provide consent, nor would have the cognitive capacity to make an informed decision about the consequences of providing consent for sexual touching.

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The PSW separated the residents immediately and notified the registered staff on duty. Follow up assessments were completed and showed no injuries or lasting impacts to the resident. The plans of care for each resident were updated in response to the incident which has decreased the risk to the resident at the time of inspection.

**Sources:** progress notes for both residents and interviews with a PSW, an RPN, and the DOC.

## **WRITTEN NOTIFICATION: Reporting certain matters to Director**

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

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Interviews with staff and a review of the documentation from the date of the incident showed an incident of sexual abuse had occurred. A review of the Ministry of Long-Term Care's online critical incident reporting system showed that the incident had not been submitted. The DOC confirmed that the incident was not reported to the Director despite being reportable based on what had happened.

**Sources:** critical incident reports from the Ministry of Long-Term Care's critical

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incident reporting website, a resident's progress notes, and interviews with a PSW, an RPN and the DOC.

## NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of \$500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Intake 00155956 was the second FUJ conducted for CO(HP) from inspection 2025-1623-0003.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.