

**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:** October 17, 2025

**Inspection Number:** 2025-1357-0002

**Inspection Type:**

Critical Incident

**Licensee:** S & R Nursing Homes Ltd.

**Long Term Care Home and City:** Afton Park Place Long Term Care Community,  
Sarnia

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 14 to 17, 2025

The following intake(s) were inspected:

- Intake #00158720/Critical Incident System (CIS) #2872-000035-25 related to allegations of improper care to residents
- Intake #00159885/CI #2872-000037-25 related to allegations of financial abuse of a resident

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

Skin and Wound Prevention and Management  
Prevention of Abuse and Neglect

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Resident Bill of Rights

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

**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.**

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:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the right of several residents to have their personal information kept confidential was upheld when staff obtained images from the electronic medical records of the residents using unauthorised hardware and software.

In an interview, it was verified that staff used a cellular device which was in violation of the long term care home's (LTCH) Pledge of Confidentiality.

**Sources:** LTCH Pledge of Confidentiality signed April 1, 2025 by staff; interview with staff

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## WRITTEN NOTIFICATION: Skin and wound program

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

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.**

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:

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee failed to comply with the home's skin and wound program when staff did not use the long term care home's (LTCH) skin and wound iPad to take photos of areas of altered skin integrity and did not assess areas of altered skin integrity at least weekly for several residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the skin and wound program were complied with. Specifically, the LTCH Skin & Wound Program policy indicated that staff were to use the "Skin and Wound App" in PointClickCare. Additionally, the LTCH Personal Cell Phone and Electronic Communication Devices policy stated that the use of personal cell phones/electronic communication devices to record or take still or video pictures of strictly prohibited.

Record reviews of the electronic medical records for three residents demonstrated incomplete skin and wound assessments on several dates over a period of time in 2025. Additionally, the LTCH investigation file demonstrated that staff did not use the LTCH skin and wound iPad to take photos and also obtained images from the

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skin and wound application in PointClickCare. An interview verified that staff had taken a photo using a cellular device for several residents, the use of which was in violation of the LTCH Skin and Wound Program policy as well as the home's Cell Phone and Electronic Communication Devices policy. Furthermore, it was also verified in an interview that staff did not complete assessments as directed by the LTCH Skin and Wound Program policy.

**Sources:** review of electronic medical records for several residents, LTCH investigation file, LTCH policy Skin & Wound Program and LTCH policy Personal Cell Phone and Electronic Communication Devices; interviews with staff

## COMPLIANCE ORDER CO #001 Skin and wound care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

**The inspector is ordering the licensee to comply with a Compliance Order**

**[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall complete the following:

1. Provide education to registered nursing staff on Maddison regarding the PointClickCare Skin and Wound app (including any applicable policies and/or supporting audio/visual materials) and maintain a written record of the staff who

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complete the education, including the following information:

- (a) date of completion of the education
- (b) name of the staff who completed the education
- (c) signature of the staff indicating understanding of the education
- (d) name of the staff providing the education
- (e) outline of content of education provided

**Grounds**

The licensee has failed to ensure that staff completed weekly reassessments of areas of altered skin integrity related to several residents on multiple occasions during four months in 2025.

Record reviews of electronic medical records for several residents and the home's investigation file demonstrated that staff did not complete assessments at least weekly on multiple occasions during four months in 2025. Documentation in the electronic medical records for several residents indicates that staff used images from previously existing assessments and also documented assessments that were incomplete. In an interview with staff it was verified that assessments were not completed at least weekly for areas of altered skin integrity on several residents on multiple occasions during four months in 2025, and also that the photos uploaded to resident's charts were images of previous assessments.

**Sources:** record review of electronic medical records for several residents and the home's investigation file; interview with staff

**This order must be complied with by** October 31, 2025.

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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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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:

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**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).