

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: January 29, 2026

Inspection Number: 2026-1165-0001

Inspection Type:

Complaint
Critical Incident

Licensee: Vision '74 Inc.

Long Term Care Home and City: Vision Nursing Home, Sarnia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22, 23, 26, 27, 28, and 29, 2026.

The following intake(s) were inspected:

- Intake: #00164761 - Complaint alleged resident to resident abuse.
- Intake: #00166548 - Critical Incident #2659-000025-25 - Improper/Incompetent treatment of a resident.
- Intake: #00168357 - Complaint alleged neglect and care and service concerns.

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

- Skin and Wound Prevention and Management
- Responsive Behaviours
- Prevention of Abuse and Neglect
- Pain Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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; and

A resident's clinical record showed a specific Point of Care (POC) task that did not provide clear direction to staff.

Sources: Resident's clinical record and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Power of Attorney (POA) for a resident was not given the opportunity to participate in the residents' plan of care related to a care concern.

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Sources: progress notes, complaint intake, interview with the Nurse Practitioner.

WRITTEN NOTIFICATION: Reporting Certain Matters To The Director

NC #003 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.

Review of resident's clinical records showed an incident between two residents. The Inspector was unable to locate a Critical Incident System report.

During an interview with the Administrator they acknowledged that a Critical Incident System report should have been completed.

Sources: Resident's clinical records and interviews with a Nurse Manager (NM) and the Administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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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;

A resident developed an area of altered skin integrity where the Inspector found that weekly wound and skin assessments were not completed weekly during a specific time period.

Sources: progress notes, weekly wound and skin assessments, interview with the Nurse Manager (NM)/Skin and Wound Lead.

WRITTEN NOTIFICATION: Police Notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

Review of two resident's clinical records showed an incident between the two residents. The Inspector was unable to locate any evidence that the police had been notified.

During an interview with the Administrator they acknowledged that the police

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should have been contacted.

Sources: Resident's clinical records and interviews with a Nurse Manager (NM) and the Administrator.

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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.

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

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

Specifically, the licensee must;

- A) Develop and implement a safety plan for a specific resident.
- B) Ensure the plan is present in the resident's care plan and communicated to direct care staff.
- C) Ensure the measures within the safety plan are documented in the resident's electronic clinical record.

Grounds

Review of resident's clinical records showed that a resident witnessed an incident between two other residents.

During an interview with the Social Worker they shared that during a meeting with the resident who witnessed the incident between the other two residents, the

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resident continued to express emotion and had set up their own interventions to protect themselves.

Sources: Resident's clinical records, an interview with a resident, the Social Worker (SW) and a Personal Support Worker (PSW).

This order must be complied with by February 12, 2026

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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

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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:

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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.