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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: January 16, 2025
Inspection Number: 2024-1165-0009
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 13-16, 2025

The following intake(s) were inspected:

- Intake: #00129895/CI # 2659-000040-24 related to missing resident
- Intake: #00129959/CI # 2659-000039-24 related to outbreak
- Intake: #00133769/IL-0134302-LO/Complaint related to resident care

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Turning and Repositioning

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee failed to turn and reposition a resident dependent on staff for repositioning every two hours. On identified dates, the resident was not turned or repositioned every two hours.

Sources: resident's care plan and documentation survey report, interview with staff.

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