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

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Public Report

Report Issue Date: June 11, 2025

Inspection Number: 2025-1165-0002

Inspection Type:
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): June 3-6, 11, 2025

The following intake(s) were inspected:

- Intake: #00146329 - CI #2659-000004-25 - Unresponsive Hypoglycemia to the resident.
- Intake: #00147293 - CI #2659-000007-25 - Related to an outbreak.

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

Medication Management
Infection Prevention and Control

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 (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.

1.The licensee failed to ensure that a resident received nutritional supplements as outlined in their care plan. The home's policy stated that nursing staff are expected to provide supplements as prescribed by a physician or dietitian. Supplements may also be offered when a resident eats half or less of their meal.

Sources: The resident's clinical records, the home's Nutritional supplement policy, and staff interviews

2.The licensee failed to ensure that blood glucose monitoring was completed as specified in the resident's care plan. The resident, who required regular checks due to a medical condition, staff failed to perform the required manual checks.

Sources: Review of resident's clinical records, observations, and staff interviews.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

The licensee failed to ensure that immediate action was taken to reduce the risk of

infection transmission when a resident showed signs of a respiratory illness.

The resident began showing symptoms of a respiratory infection and continued to display symptoms the next day. Although isolation measures were reportedly started the next day, there was no clear documentation of when they began or whether all staff were informed. Some staff were unsure of the resident's isolation status, and the resident was seen outside their room without any indication or documentation of their isolation status. The lack of clear communication and documentation caused confusion amongst the staff.

Sources: Review of Resident's clinical records, Outbreak Line List, home's policy on management of ARIs; and staff interviews.

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that written policy related to documenting as-needed (PRN) medication was followed.

In accordance with Section 11(1)(b) of Ontario Regulation 246/22, where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy the licensee was required to ensure that the policy was complied with.

The home's policy requires staff to verify and record all PRN medications in the electronic medication record. On one occasion, a resident was given a medication in response to a serious health event, but the administration was not documented in the system as required. Although the resident had a standing order for the medication, the lack of documentation showed the event was not properly recorded, which could impact continuity of care and oversight.

Sources: The resident's clinical record, Pharmacy policy titled "PRN Medication"; Critical Incident report, and staff interviews.