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

# Original Public Report

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|---|---|
| **Report Issue Date:** April 14, 2023 | |
| **Inspection Number:** 2023-1382-0002 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** S & R Nursing Homes Ltd. | |
| **Long Term Care Home and City:** Heron Terrace Long Term Care Community, Windsor | |
| **Lead Inspector**<br>Cassandra Taylor (725) | **Inspector Digital Signature**<br>Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2023.04.17 08:09:37 -04'00' |
| **Additional Inspector(s)**<br>Julie DAlessandro (739)<br>Adriana Congi (000751) was present during their orientation period. | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 5, 2023

The following intake(s) were inspected:
Intake: #00017304 - Complaint - Relating to care concerns.
Intake: #00008445 - Critical Incident (CI) #2898-000007-22 - Relating to an injury of unknown origin.
Intake: #00018359 - CI #2898-000002-23 - Relating to Falls Prevention and Management

The following intakes were completed in this inspection: Intake #00007627, CI #2898-000006-22, Intake #00010724, CI #2898-000010-22, Intake #00015002, CI #2892-000011-22, Intake #00008445, CI #2898-000007-22, were related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (9) 1.

The plan of care for a resident did not include written direction to staff on the resident's ability to preform specific tasks.

The Manager of Resident Care (MRC), indicated the resident was able to preform specific tasks.

The physician wrote specific orders and the MRC ensured the care plan was updated to include the required information for staff.

Sources: The resident's records, physician orders and staff interview with the MRC.

Date Remedy Implemented: April 5, 2023