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: October 23, 2025
Inspection Number: 2025-1382-0007
Inspection Type: Critical Incident
Licensee: S & R Nursing Homes Ltd.
Long Term Care Home and City: Heron Terrace Long Term Care Community, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 20, 21, 23, 2025

The following intake(s) were inspected:

- Intake: #00156727 - AH-2025-0002211/2898-000032-25 related to Infection Prevention and Control
- Intake: #00156919 - AH-2025-0002313 /2898-000034-25 related to the fall of a resident
- Intake: #00157147 - 2898-000036-25 - related to the alleged neglect of a resident

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

Infection Prevention and Control
Pain Management
Falls Prevention and Management

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.

The licensee failed to ensure that the care set out in the plan of care of a resident was provided to that resident. A staff member failed to assess the resident and to provide relief when resident was in pain. The staff member acknowledged in an interview that they did not assist the resident when they were in pain and attended to the resident only when their pain medication was scheduled to be administered.

Sources: resident's clinical record, investigation notes, interviews with staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 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.

The licensee failed to ensure that a report was immediately submitted to the Director when a suspicion of abuse and neglect of a resident occurred and was submitted late.

A resident was in pain and a staff member failed to assess the resident and provide them with relief.

Sources: review of Critical Incident and investigation notes, interview with staff.

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