

**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:** August 7, 2025

**Inspection Number:** 2025-1374-0002

**Inspection Type:**

Critical Incident

**Licensee:** S & R Nursing Homes Ltd.

**Long Term Care Home and City:** Twin Lakes Terrace Long Term Care  
Community, Sarnia

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 5-7, 2025.

The following intake was inspected:

- Critical Incident (CI) #2889-000015-25 related to allegations of staff to resident abuse.

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

Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**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 a resident was provided nutrition care as specified in their plan of care.

The resident's plan of care indicated they had a nutrition intervention in place and they were not provided with this nutrition intervention as specified in their plan of care at a meal on a particular date.

**Sources:** the CI report; the resident's clinical record, including nutrition assessments and care plan; the home's Menu Stream software system; and staff interviews.

**WRITTEN NOTIFICATION: Dining and snack service**

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

**Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.**

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

6. Sufficient time for every resident to eat at their own pace.

The licensee failed to ensure that the dining and snack service in the home provided a resident sufficient time to eat at their own pace.

The home's policies related to meal service and resident safety in the dining room directed staff to give residents a comfortable and adequate amount of time to

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complete their meal to promote residents' enjoyment, safety, comfort, independence and dignity in eating.

The resident's plan of care directed staff to provide the resident with assistance for eating at a specific pace. A Personal Support Worker (PSW) was assisting the resident with eating at a pace that was not in accordance with the residents care requirements.

**Sources:** the CI report; the home's investigation notes related to the incident; the resident's clinical record, including progress notes, nutrition assessments and care plan; the home's "Meal Service" and "Resident Safety in the Dining Room" policies; and staff interviews.