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
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# Public Report

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| **Report Issue Date:** December 2, 2025 |
| **Inspection Number:** 2025-1374-0003 |
| **Inspection Type:**<br>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 dates: November 27-28, 2025 and December 1-2, 2025

The following Critical Incident (CI) intakes were inspected:

- CI #2889-000021-25 related to falls prevention and management; and
- CI #2889-000025-25 related to allegations of neglect.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.**
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,

ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

A new physicians order for a medication was obtained for a resident. Their Power of Attorney (POA) was notified of the new order; however, consent was not obtained for the order at that time.

Four days later a staff member faxed this new order to the home's pharmacy for processing and the resident was subsequently administered the medication. Consent had not been obtained from the resident's POA when this medication was administered, and they were not made aware the resident had been administered this medication until approximately two weeks after it was administered.

**Sources:** CI report; the home's investigation notes related to the incident; the resident's clinical record, including progress notes and Medication Administration Record (MAR); and staff interviews.