



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des Soins
de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection prévue
sous la Loi de 2007 sur les foyers
de soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 16, 2019	2019_607523_0021	008612-19	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

Richmond Terrace
89 Rankin Avenue AMHERSTBURG ON N9V 1E7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALI NASSER (523)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 13, 2019

This inspection was conducted for Complaint Intake Log #008612-19, IL-66221-LO-related to allegation of family to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, two Personal Support Workers and a Registered Nurse.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, investigation notes and reviewed specific policies and procedures of the home.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

3 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance



Specifically failed to comply with the following:

- s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
- (a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
 - (b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
 - (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
 - (d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
 - (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
 - (f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
 - (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
 - (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

A review with the Administrator of the home's policy subject "Abuse-Prevention, Elimination & Reporting Policy". Effective Date: September 2018, showed that the policy to promote zero tolerance of abuse and neglect of residents did not contain an explanation of the duty under section 24 of the act to make mandatory report. The review also showed a wrong reference to Ontario Regulation 79/10, s. 97 (1).

The administrator said that they were working on obtaining new policies and procedures for the home. [s. 20. (2)]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :



1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to allegations of family to resident abuse.

Complainant said that they informed the home on the day of the alleged incident, they did not hear anything back from the home, and then they informed the DOC in person 10 days after the incident about the allegations of abuse, the complainant said that the DOC informed them 12 days later that they were not able to conclude anything.

The DOC said they were made aware of the allegations. The DOC said that they did not immediately initiate an investigation when they were informed of the allegations of resident's abuse.

The Administrator said in an interview that the allegations of abuse should have been immediately investigated to ensure that the resident was safe. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A complaint was received on certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to allegations of family to resident abuse. Complainant said in an interview that they informed the home about allegations of abuse that resulted in harm or risk of harm to the resident.

In an interview the DOC said that on a certain date they were made aware of the allegations of abuse but they missed on completing a Critical Incident System (CIS) report and inform the Director about those allegations.

In an interview the Administrator said that on a certain date they were made aware about the allegations of abuse. The Administrator said they missed on completing a CIS and reporting to the Director.

The Administrator said that it was the expectation to inform the Director once they were made aware of those allegations. [s. 24. (1)]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 16th day of May, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.