

**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

**Report Issue Date:** September 29, 2023

**Inspection Number:** 2023-1038-0003

**Inspection Type:**

Complaint  
Critical Incident

**Licensee:** Richmond Terrace Limited

**Long Term Care Home and City:** Richmond Terrace, Amherstburg

**Lead Inspector**

Julie D'Alessandro (739)

**Inspector Digital Signature**

**Additional Inspector(s)**

Adriana Congi (000751)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25, 26, and 27, 2023.

The following intake(s) were inspected:

Intake: #00088620/CI# 1149-000025-23 related to fall prevention and management

Intake: #00095811/CI #1149-000043-23 related to outbreak management

Intake: #00097052/CI #1149-000046-23 related to skin and wound management

Intake: #00096845 complaint related to infection control and medication management

The following intake was also completed in this inspection: Intake: #00096928/CI #1149-000045-23 related to falls prevention and management.

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

Skin and Wound Prevention and Management

Infection Prevention and Control

Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Skin and Wound Care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

**Introduction:**

The licensee failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

**Rationale and Summary:**

A progress note documented in Point Click Care (PCC) indicated that a resident had areas of altered skin integrity.

Review of the resident's skin and wound assessment tab in PCC had not included weekly assessment of the areas.

During an interview with two registered staff and the Director of Clinical Services, they stated that the areas of impaired skin integrity should have been assessed and documented weekly and were not.

**Sources:** Resident's progress notes and weekly wound assessment tab in PCC as well as interviews with two registered staff and the Director of Clinical Services.