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
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Original Public Report

Report Issue Date: November 2, 2023	
Inspection Number: 2023-1038-0004	
Inspection Type: Complaint	
Licensee: Richmond Terrace Limited	
Long Term Care Home and City: Richmond Terrace, Amherstburg	
Lead Inspector Julie D'Alessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.11.03 12:59:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30 and 31, 2023

The following intake(s) were inspected:
- Intake: #00100179- Complaint related to falls prevention and management

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

Infection Prevention and Control
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)

Introduction:
The licensee failed to ensure that the plan of care for a resident was provided to them as specified in the plan.

Rationale and Summary:
An intervention was documented in a resident's plan of care that had not been followed by staff. According to the progress notes the resident then had a fall.

During an interview with the Director of Clinical Services (DOCS), they acknowledged that the resident was not provided the care needed as specified in their plan.

Sources: Resident' plan of care and progress notes as well as an interview with the DOCS.
[739]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Introduction:
The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered staff, using a clinically appropriate instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:
A progress note written by a registered staff member, indicated that a resident was assessed and had several areas of altered skin integrity. There was no further documentation found within the resident's chart showing that a clinically appropriate instrument that was specifically designed for skin and wound assessment was completed for the resident. The resident required further intervention.

During an interview with the registered staff they stated that they had completed the documentation in the progress notes but that a separate assessment had not been completed for the areas of altered skin integrity.

During an interview with the DOCS they acknowledged that the resident had sustained areas of altered skin integrity and that an assessment should have been completed using a clinically appropriate instrument that was specifically designed for skin and wound but was not.

Sources: The resident's progress notes and staff interviews.
[739]