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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Public Report

Report Issue Date: December 20, 2024
Inspection Number: 2024-1038-0004
Inspection Type: Critical Incident
Licensee: Richmond Terrace Limited
Long Term Care Home and City: Richmond Terrace, Amherstburg

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 3 - 6, 2024, and December 9, 2024

The following intakes were inspected:

- Intake: #00127548 / Critical Incident (CI) #1149-000036-24 - related to alleged abuse and neglect
- Intake: #00130692 / CI #1149-000041-24 - related to improper/incompetent treatment
- Intake: #00133378 / C #1149-000050-24 - related to alleged abuse and neglect

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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)
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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The home submitted a critical incident report to the Ministry of Long-Term Care advising that a complaint was received alleging neglect to a resident related to care not being followed as per the plan of care.

The resident's plan of care had specified the times the resident was to have care performed. A staff member confirmed the resident was not provided care at the specified times, as per the plan of care.

When the resident was not provided care as per their plan of care, there was risk to the resident's health and wellbeing.

Sources: Critical incident report, review of the resident's clinical records, and interview with staff

WRITTEN NOTIFICATION: Consent

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure they received consent from a resident's Power of Attorney (POA) before holding a medication.

Summary and Rationale
The home received a complaint from a resident's POA, and submitted a CI report to the Ministry of Long-Term Care.

During a review of the resident progress notes and Physician/Nurse Practitioner orders sheets, no documentation was found to support that consent was obtained when a medication was held. In an interview with staff, it was acknowledged that consent was not obtained from the POA.

Not obtaining consent, impacted the POA's ability to fully participate in the resident's care plan, and advocate for resident's needs and preferences. Therefore, there was a risk that the resident did not receive appropriate treatment.

Sources: Critical Incident report, review of the resident's clinical record, and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure the home's Transfer Policy was in place and ensure it was complied with.

Specifically, staff did not comply with the licensee's requirement to use a transfer device when transferring, as part of the policy titled "Body Mechanics: Moving, Positioning, Transfers".

Rationale and Summary
The home submitted a critical incident report advising that a resident had an improper transfer, which resulted in injury. The Transfer Policy, "Body Mechanics: Moving, Positioning, Transfers" stated a transfer device is to be used for specified transfer.

During an interview with staff, they confirmed the transfer device was not used. Another staff member also confirmed the transfer was not safe as the device was not used.

Failure to transfer the resident using a safe transferring technique resulted in injury.

Sources: Interviews with staff, Transfer Policy: "Body Mechanics: Moving, Positioning, Transfers", and review of the resident's clinic records