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

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Public Report

Report Issue Date: June 20, 2025
Inspection Number: 2025-1038-0003
Inspection Type: Complaint Critical Incident
Licensee: Richmond Terrace Limited
Long Term Care Home and City: Richmond Terrace, Amherstburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16, 17, 19, 20, 2025

The following intake(s) were inspected:

- Intake: #00147295 -IL-0140197- related to a complaint surrounding resident care
- Intake: #00149415 -1149-000044-25 - related to Infection Management and Control

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Post Outbreak Summary of Findings

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

As per section 4.3 of the IPAC Standards issued by the Director, "The licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices."

It was established in interviews that a summary of findings was not created that made recommendations to the licensee for improvements to outbreak management practices.

Sources: IPAC Standards, interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift while in isolation, two residents had their symptoms of infection monitored. During interviews, it was confirmed that infection monitoring was expected to be completed on every shift while a resident is in isolation. The staff member also confirmed that there were several shifts where infection monitoring was not completed while the same two residents were in isolation.

Sources: review of resident records and interview.