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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: September 11, 2025

Inspection Number: 2025-1038-0005

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Richmond Terrace Limited

Long Term Care Home and City: Richmond Terrace, Amherstburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-5 and 8-11, 2025.

The following intake(s) were inspected:

-Follow-up Intake: #00154341 - Follow-up #01 - Compliance Order (CO) #001 from inspection #2025_1038_0004 related to O.Reg 246/22 s. 121 7.- prohibited devices that limit movement. CDD: September 8, 2025.

-Complaint Intake: #00157012 - relating to care concerns.

-Critical Incident (CI) Intake: #00154987 - CI #1149-000068-25 - relating to Infection Prevention and Control (IPAC).

-CI Intake: #00156323 - CI #1149-000073-25 - relating to IPAC.

-CI Intake: #00155286 - CI #1149-000070-25 - relating to an unexpected death of

resident.

-CI Intake: #00155289 - CI #1149-000071-25 - relating to a medication incident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1038-0004 related to O. Reg. 246/22, s. 121 7.

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

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Residents' Rights and Choices
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 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 failed to ensure on every shift, two resident's symptoms indicating the presence of infection were monitored and documented.

Specifically, for one of the residents, symptoms were not monitored and documented for three evening shifts, during a period of time, while the resident was exhibiting symptoms and had been in isolation during a respiratory outbreak.

Also, another resident's symptoms were not monitored and documented for a number of shifts, during an eight day period, while the resident was exhibiting symptoms and had been in isolation during a respiratory outbreak.

Sources: Resident's clinical records, home's Outbreak Management Program, and interviews with the Infection Prevention and Control (IPAC) Lead.

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