

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: January 14, 2026

Inspection Number: 2026-1038-0001

Inspection Type:
Critical Incident

Licensee: Omni Quality Living (Southwest) Limited Partnership by its general partner
Omni Quality Living (Southwest) GP Ltd.

Long Term Care Home and City: Richmond Terrace, Amherstburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 12, 13, and 14, 2026.

The following intake(s) were inspected related to falls prevention and management:
Intake #00164514/CI #1149-000101-25
Intake #00166335/CI #1149-000102-25

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

Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

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Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident.

A resident had a fall intervention in place. Observations and interviews determined that the resident used this intervention however, it was not documented in their plan of care. The resident's plan of care was updated on January 13, 2026, to include the intervention.

Sources: Progress notes, plan of care, observation and staff interview.

Date Remedy Implemented: January 13, 2026