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

Original Public Report

Report Issue Date: May 11, 2023	
Inspection Number: 2023-1038-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Richmond Terrace Limited	
Long Term Care Home and City: Richmond Terrace, Amherstburg	
Lead Inspector Julie DAlessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.05.11 15:40:23 -04'00'
Additional Inspector(s) Adriana Congi (000751) Jennifer Bertolin (740915)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 3, 4, 5, 8, 9, and10, 2023

The following intake(s) were inspected:

- Intake: #00084146 - CI #1149-000008-23 related to alleged abuse
- Intake: #00084540- Complaint related to resident care and support services

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Recreational and Social Activities
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

A resident was involved in an incident. Assessments were completed and the plan of care was not revised when the resident's care needs changed. During staff interviews they acknowledged that the resident's plan of care was not revised when their care needs changed.

On a later date the plan of care was reviewed again and reflected the resident's current care needs.

Sources: progress notes, plan of care, resident observation, and staff interviews
[739]

Date Remedy Implemented: May 5, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 274 (b)

The licensee failed to ensure that a resident's record was kept up to date at all times.

A resident was involved in an incident. As a result of the incident there were new medical diagnoses. A review of the resident's chart did not include the new diagnoses and this was acknowledged by a member of the management team.

On a later date the diagnoses were reviewed and had been updated in the resident's clinical chart.

Sources: progress notes, medical diagnoses tab, and staff interview

[739]

Date Remedy Implemented: May 5, 202

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care. The CI report indicated in part that a resident was to have had an intervention in place at the time of an incident but they did not. The resident's chart also indicated that the intervention should have been in place.

A staff member stated that the intervention was not available on the day of the incident. A member of the management team acknowledged that the intervention should have been in place and was not.

Sources: CI report, the resident's clinical record, and staff interviews.
[739]

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the provision of care set out in the plan of care for a resident was documented.

A CI report was submitted to the Ministry of Long-Term Care indicating there had been an incident between two residents. The CI report was amended to include a safety intervention for one of the residents. Record review of the resident's chart showed no documentation related to this safety intervention for several shifts within a two month period. During staff interviews they stated that if the documentation was not there then it had been missed.

Sources: CI report, a resident's clinical record, and staff interviews.

[739]

WRITTEN NOTIFICATION: Duty to Protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from abuse by another resident .

Ontario Regulation 246/22 defines physical abuse as, "the use of physical force by a resident that causes physical injury to another resident".

A CI report was submitted to the Ministry of Long-Term Care. The CI report indicated that there was an incident between two resident which caused injury to one resident. A member of the management team acknowledged that one resident caused injury to another resident during this incident. Video recording of this incident was viewed by the inspector.

Sources: CI report, a resident's clinical chart, and video footage.
[739]

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