

**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:** March 14, 2024

**Inspection Number:** 2024-1038-0001

**Inspection Type:**

Proactive Compliance Inspection

**Licensee:** Richmond Terrace Limited

**Long Term Care Home and City:** Richmond Terrace, Amherstburg

**Lead Inspector**

Julie D'Alessandro (739)

**Inspector Digital Signature**

**Additional Inspector(s)**

Cheryl McFadden (745)

Loma Puckerin (705241)

Joy Kacsandi (000821) was also present during this inspection

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 11, 12, 13, 2024

The following intake(s) were inspected:

- Intake: #00109722- Proactive Compliance Inspection

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management
- Food, Nutrition and Hydration
- Residents' and Family Councils
- Infection Prevention and Control

**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

Prevention of Abuse and Neglect  
Quality Improvement  
Residents' Rights and Choices  
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. 85 (3) (a)**

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,  
(a) the Residents' Bill of Rights

### Introduction

The licensee failed to ensure that the resident's bill of rights was posted in the home, in a conspicuous and easily accessible location.

### Rationale and Summary

On March 6, 2024, it was observed that the resident's bill of rights was posted in the basement on a wall leading to the back door of the building. The Director of Clinical Services (DOCS) recognized that this was not a conspicuous and easily accessible location. There was risk that residents were unaware of where to find information

**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

that was to be posted.

On March 8, 2024, the bill of rights was observed on the second floor of the home, inside the entrance, in an easily accessible location.

**Sources:** observation and staff interview.  
[739]

Date Remedy Implemented: March 8, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: FLTCA, 2021, s. 85 (3) (c)**

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,  
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents

**Introduction**

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location.

**Rationale and Summary**

On March 6, 2024, it was observed that the policy to promote zero tolerance of abuse and neglect of residents was in a binder, labelled Public Access, outside the administration offices in the basement. The DOCS recognized that this was not a conspicuous and easily accessible location.

On March 8, 2024, the policy to promote zero tolerance of abuse and neglect of residents was observed in a binder, labelled Public Access, on the second floor of

**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

the home, inside the entrance in an easily accessible location.

**Sources:** observation and staff interview.  
[739]

Date Remedy Implemented: March 8, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: FLTCA, 2021, s. 85 (3) (d)**

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,  
(d) an explanation of the duty under section 28 to make mandatory reports

**Introduction**

The licensee failed to ensure that an explanation of the duty to make mandatory reports was posted in the home, in a conspicuous and easily accessible location.

**Rationale and Summary**

On March 6, 2024, it was observed that an explanation of the duty under section 28 to make mandatory reports was in a binder, labelled Public Access, outside the administration offices in the basement. The DOCS recognized that this was not a conspicuous and easily accessible location.

On March 8, 2024, an explanation of the duty to make mandatory reports was observed in a binder, labelled Public Access, on the second floor of the home, inside the entrance in an easily accessible location.

**Sources:** observation and staff interview.  
[739]

**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

Date Remedy Implemented: March 8, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: FLTCA, 2021, s. 85 (3) (f)**

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,  
(f) the written procedure, provided by the Director, for making complaints to the  
Director, together with the contact information of the Director, or the contact  
information of a person designated by the Director to receive complaints

**Introduction**

The licensee failed to ensure that the written procedure and contact information for making complaints to the Director was posted in the home, in a conspicuous and easily accessible location.

**Rationale and Summary**

On March 6, 2024, it was observed that the written procedure and contact information for making complaints to the Director was only located on the third floor on the West unit. The DOCS recognized that this was not a conspicuous and easily accessible location.

On March 8, 2024, the written procedure and contact information for making complaints to the Director was observed on the second floor of the home, inside the entrance in an easily accessible location.

**Sources:** observation and staff interview.  
[739]

Date Remedy Implemented: March 8, 2024

**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

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: FLTCA, 2021, s. 85 (3) (r)**

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,  
(r) an explanation of the protections afforded under section 30

**Introduction**

The licensee failed to ensure that an explanation related to whistle blower protection was posted in the home, in a conspicuous and easily accessible location.

**Rationale and Summary**

On March 6, 2024, it was observed that an explanation related to whistle blower protection was in a binder, labelled Public Access, outside the administration offices in the basement. The DOCS recognized that this was not a conspicuous and easily accessible location.

On March 8, 2024, an explanation related to whistle blower protection was observed in a binder, labelled Public Access, on the second floor of the home, inside the entrance in an easily accessible location.

**Sources:** observation and staff interview.

[739]

Date Remedy Implemented: March 8, 2024

**WRITTEN NOTIFICATION: Resident and Family/Caregiver  
Experience Survey**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**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

**Non-compliance with: FLTCA, 2021, s. 43 (4)**

Resident and Family/Caregiver Experience Survey

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

**Introduction**

The licensee failed to seek the advice of the residents' council in carrying out the resident and family/caregiver experience survey and in acting on its results.

**Rationale and Summary**

During a review of the resident council meeting minutes from 2023, there was no indication that the resident council was consulted regarding family/caregiver experience survey and in acting on its results.

The home's Executive Director (ED) acknowledged that the home did not seek the advice of the residents' council in carrying out the resident and family/caregiver experience survey and in acting on its results. There was a risk that residents had areas of concern that were not addressed in the survey and residents did not have input when acting on its results.

**Sources:** resident council meeting minutes and staff interview  
[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.**

**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

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

3. The home's Medical Director.

**Introduction**

The licensee failed to ensure that the continuous quality improvement (CQI) committee included the home's Medical Director.

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by the Medical Director. The Executive Director (ED) stated that they had a CQI committee, but the Medical Director was not on the committee.

The quality improvement (QI) policy stated the organization will have a Quality Improvement Committee under the supervision of the Vice President of Quality and Innovation but did not indicate who the committee needed to be comprised of. Input from all required persons was not obtained when developing quality improvement initiatives in the home, when there wasn't a CQI committee with the required membership.

**Sources:** QI meeting minutes, QI policy, and staff interview.

[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.**



**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

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

5. The home's registered dietitian.

**Introduction**

The licensee failed to ensure that the CQI committee included the home's Registered Dietitian (RD).

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by the RD. The ED stated that they had a CQI committee, but the RD was not on the committee.

**Sources:** Sources: CQI meeting minutes and staff interview.

[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.**

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

**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

**Introduction**

The licensee failed to ensure that the CQI committee included the home's pharmacy service provider, or where the pharmacy service provider was a corporation, a pharmacist from the pharmacy service provider.

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by the home's pharmacy service provider/pharmacist. The ED stated that they had a CQI committee, but the pharmacy provider/pharmacist was not on the committee.

**Sources:** CQI meeting minutes and staff interview.

[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.**

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

**Introduction**

The licensee failed to ensure that the CQI committee included at least one employee of the licensee who was a member of the regular nursing staff of the

**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

home.

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by a regular nursing staff member of the home. The ED stated that they had a CQI committee, but an employee who was a regular nursing staff of the home was not on the committee.

**Sources:** CQI meeting minutes and staff interview.

[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.**

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

**Introduction**

The licensee failed to ensure that the CQI committee included at least one employee of the licensee who had been hired as a personal support worker (PSW) or provided personal support services in the home.

**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

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by a PSW. The ED stated that they had a CQI committee, but an employee of the home who had been hired as a PSW was not on the committee.

**Sources:** CQI meeting minutes and staff interview.  
[739]

**WRITTEN NOTIFICATION: Continuous Quality Improvement  
Committee**

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.**

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

9. One member of the home's Residents' Council.

**Introduction**

The licensee failed to ensure that the CQI committee included one member of the home's Residents' Council.

**Rationale and Summary**

The CQI meeting minutes on April 27, July 20, and October 19, 2023, and January 25, 2024, did not include attendance by a member of the Residents' Council. The ED stated that they had a CQI committee, but a member of the Residents' Council was not on the committee.

**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

**Sources:** CQI meeting minutes and staff interview.

[739]

## **WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report**

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 168 (1)**

Continuous quality improvement initiative report

s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

### **Introduction**

The licensee failed to ensure a report was prepared on the CQI initiative for the home for each fiscal year, no later than three months after the end of the fiscal year and published a copy of each report on its website.

### **Rationale and Summary**

The home's website included the Health Quality Ontario Quality Improvement Plan Narrative and Workplan for 2015/2016. There was no other Quality Improvement (QI) report posted on the home's website. The DOCS stated that they created a strategic plan and narrative, that included quality improvement initiatives, but did not create the QI report.

The home's QI policy did not include the requirement to create a report or publish it on the home's website. There was risk that all required improvements were not

**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

addressed or followed up on when the home did not create the required QI Initiative report.

**Sources:** Richmond Terrace 2023-2024 strategic plan, the home's QI policy, and staff interview.

[739]