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: April 16, 2024
Inspection Number: 2024-1038-0002
Inspection Type: Complaint Critical Incident
Licensee: Richmond Terrace Limited
Long Term Care Home and City: Richmond Terrace, Amherstburg

Lead Inspector	**Inspector Digital Signature**
Cassandra Taylor (725)	Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2024.04.17 09:07:33 -04'00'

Additional Inspector(s)
Clare Hoevenaars (000834) was present for this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11, 12, 15, 2024

The following intake(s) were inspected:

- Complaint Intake: #00101701 - relating to care concerns.
- Complaint Intake: #00104302 - relating to allegations of abuse and neglect.
- Complaint Intake: #00111652 - relating to care concerns.
- Critical Incident (CI) Intake: #00111637 - CI #1149-000013-24 - relating to allegations of abuse and neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
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) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that there was clear direction to staff relating to the transfer status of a resident.

During an observation a transfer logo was identified within the resident's wardrobe. Review of the resident's clinical records indicated the resident was assessed and care planned to be a different status than posted.

During an interview with the Assistant Director of Care and Services (ADOCS) who confirmed the sign in the wardrobe was incorrect and that the resident was a specific transfer status.

The ADOCS changed the sign in resident's wardrobe..

Sources: Observation of resident's wardrobe, clinical records and staff interview.

[725]

Date Remedy Implemented: April 15, 2024