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
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Public Report

Report Issue Date: May 6, 2025
Inspection Number: 2025-1038-0002
Inspection Type: Complaint Critical Incident
Licensee: Richmond Terrace Limited
Long Term Care Home and City: Richmond Terrace, Amherstburg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28-30, 2025 and May 1, 2, 5, 6, 2025

The following intake(s) were inspected:
Intake: #00140588 -1149-000013-25 - ARI- COVID - Outbreak declared on February 21, 2025- finalized March 17, 2025- 3 West
Intake: #00143253 -1149-000018-25 - Related to alleged physical abuse.
Intake: #00143363 -1149-000020-25 - Related to alleged verbal abuse.
Intake: #00143723 -IL-0138510-AH/1149-000022-25 - Related to improper/incompetent treatment of a resident.
Intake: #00145017 - Complaint related to resident care and support services.
Intake: #00145150 - Complaint related to resident care and support services.
Intake: #00145887 -1149-000031-25 - ARI - COVID- Outbreak declared April 24, 2025 - ongoing April29, 2025- 2 West
Intake: #00145890 -1149-000030-25 - Related to fall prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a staff member, who had reasonable grounds to suspect that a staff member physically abused a resident and verbally abused another resident, immediately reported to the Director.

A) On a specific date, a staff member submitted an internal concern form to a management team member alleging that they had witnessed a staff member physically abuse a resident when the resident was attempting to be inappropriate during care. The management team member did not receive the concern form with the allegation until after the date mentioned.

B) On a specific date, a staff member sent an e-mail to a management team member alleging that they had witnessed a staff member verbally abuse a resident

before providing care. The staff member reported this allegation two days after the alleged incident occurred.

Sources: Review of Critical Incident (CI) reports, the home's internal concern form, e-mail communication, and an interview with a management team member

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident . According to the care plan, the resident was assessed for a specific type of transfer lift that requires two-person assistance for safe transfers. On a specific date, a staff member transferred the resident alone, resulting in a fall that caused injury.

Sources: Review of CI report, record reviews, and an interview with a staff member.