



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 9, 2015	2014_303563_0065	009006-14	Complaint

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### **Licensee/Titulaire de permis**

OAKWOOD RETIREMENT COMMUNITIES INC.  
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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### **Long-Term Care Home/Foyer de soins de longue durée**

THE VILLAGE OF RIVERSIDE GLEN  
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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### **Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

MELANIE NORTHEY (563)

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## **Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): December 30, 2014**

**During the course of the inspection, the inspector(s) spoke with the Director of Nursing, the Assistant Director of Nursing, the Neighbourhood Coordinator and the Resident. The inspector also made observations, reviewed health records, policies and other relevant documentation.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend

WN – Written Notification  
VPC – Voluntary Plan of Correction  
DR – Director Referral  
CO – Compliance Order  
WAO – Work and Activity Order

Legendé

WN – Avis écrit  
VPC – Plan de redressement volontaire  
DR – Aiguillage au directeur  
CO – Ordre de conformité  
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the "Wound / Skin Care" Policy Tab 04-78 dated January 2015 in place was complied with.

Record review of the "Wound / Skin Care" Policy Tab 04-78 revealed a "QI PROTOCOL" that the, "Resident's Power of Attorney (POA) will be informed." The Director of Nursing (DON) confirmed the POA should be notified of any skin concern, including bruising.

Review of progress notes revealed the resident was noted to have sustained an injury.

Review of progress notes revealed the resident's POA was in to visit and saw the injury. POA was not informed of the injury prior to visiting the resident.

The DON confirmed it is the home's expectation that the POA be notified and/or consulted with on the proposed treatment plan for any change of plan or new concern. [s. 8. (1) (b)]

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**Issued on this 9th day of February, 2015**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**