



**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>
Nov 13, 2014	2014_303563_0053	000188-14	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**

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

**This inspection was conducted on the following date(s): November 10, 2014**

**During the course of the inspection, the inspector(s) spoke with the Acting General Manager, the Director of Nursing, the Neighbourhood Coordinator and two Personal Support Workers.**

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



Prevention of Abuse, Neglect and Retaliation Safe and Secure Home

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

2 WN(s)

1 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 LTCHA, 2007 S.O. 2007, c.8, s. 24.  
Reporting certain matters to Director**

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

**s. 24. (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:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

Record review of the home's investigation notes revealed interviews regarding the incident were conducted 3 days before the critical incident was reported to the Ministry of Health.

Record review of the progress notes revealed an incident occurred causing an injury to the resident.

[REDACTED]

Staff interview with the Acting General Manager (AGM) and Director of Nursing (DON) confirmed they were aware of the CI [REDACTED]. DON confirmed all registered staff are trained to submit a CI and the AGM confirmed a CI should have been submitted upon the discovery of an injury related to the alleged mistreatment of the resident [REDACTED]. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**



Specifically failed to comply with the following:

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Record review of the home's investigation notes revealed interviews [REDACTED] [REDACTED] with the staff involved.

Record review of the progress notes revealed an incident occurred causing injury to the resident and resident's daughter was not made aware of the incident and injury.

Record review of the resident's chart revealed the resident's daughter is the Power of Attorney (POA).

Staff interview with the Neighbourhood Coordinator confirmed staff did not immediately notify the POA upon becoming aware of the alleged incident of abuse that resulted in a physical injury to the resident.

Staff interview with the Acting General Manager and the Director of Nursing confirmed it is the home's expectation that POA/family are notified of all allegations of abuse and/or injury as soon as possible. [s. 97. (1) (a)]



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**Issued on this 17th day of November, 2014**

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

**Original report signed by the inspector.**