

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 prévue le Loi de 2007 les foyers de soins de longue

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 performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 22, 23, 31, Jun 8, 2012	2012_089115_0028	Complaint
Licensee/Titulaire de permis		
DIVERSICARE VI LIMITED PARTNEI 458 Glencairn Avenue, TORONTO, O Long-Term Care Home/Foyer de so	N, M5N-1V7	
CHELSEY PARK (OXFORD) NURSIN 310 OXFORD STREET WEST, LONE		
Name of Inspector(s)/Nom de l'insp	ecteur ou des inspecteurs	
TERRI DALY (115)		
	nspection Summary/Résumé de l'insp	ection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Practical Nurse, the Nurse Administration Clerk, and one Personal Support Worker.

During the course of the inspection, the inspector(s) reviewed the clinical record of one resident, the investigative file, and policies and procedures related to Log# L-000457-12.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
Legend	Legendé	
	WN = Avis écrit VPC = Plan de redressement volontaire DR = Aiguillage au directeur CO = Ordre de conformité WAO = Ordres : travaux et activités	



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the 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 LTCHA includes the requirements contained in the items listed in 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.

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 subsections:

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

Findings/Faits saillants:

1. A critical incident report was not completed and filed with the Director/MOHLTC related to an incident of improper or incompetent treatment or care of a resident.

The Administrator and Director of Care confirm that a critical incident report was not filed. [LTCHA, 2007, S.O. 2007, c.8, s.24(1)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 improper or incompetent treatment or care of a resident by anyone that resulted in harm or risk of harm is reported immediately to the Director, to be implemented voluntarily.

Issued on this 8th day of June, 2012

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