



**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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2013	2013_260521_0004	L-000920-13	Critical Incident System

Licensee/Titulaire de permis

DIVERSICARE VI LIMITED PARTNERSHIP
458 Glencairn Avenue, TORONTO, ON, M5N-1V7

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

CHELSEY PARK (OXFORD) NURSING HOME
310 OXFORD STREET WEST, LONDON, ON, N6H-4N6

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

REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 27, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, a Registered Nurse In Charge, a Personal Support Worker, The Educational Coordinator, a Resident.

During the course of the inspection, the inspector(s) reviewed a Critical Incident, a Clinical Record, staff training pertaining to Falls Prevention, and observations of the resident's living quarters.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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



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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.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :



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1. The licensee did not provide an analysis and follow-up action in writing within 10 days to the Director that included:

- a) the immediate actions that have been taken to prevent recurrence, and
- b) the long term actions planned to correct the situation and/or prevent recurrence.

A critical incident was submitted and did not include any analysis and or and follow up action(s) to determine any preventative measures for both short and long term actions.

This was confirmed by the Director of Care. [s. 107. (4) 4.]

Issued on this 28th day of November, 2013

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

REBECCA DEWITTE