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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 17, 2023

Inspection Number: 2023-1164-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Chartwell Master Care LP

Long Term Care Home and City: Ballycliffe Long Term Care Residence, Ajax

Lead Inspector	**Inspector Digital Signature**
Rodolfo Ramon (704757)	Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2023.11.01 10:58:30 -04'00'

Additional Inspector(s)
Najat Mahmoud (741773)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 13-15, 18, 20, 21, 2023

The following intake(s) were inspected:

- Intake: #00095781 - a complaint related to meal service, pain management, sleep patterns
- Intake: #00021393 - was related to a fall with injury.

The following intake(s) were completed:

- #00016281 and #00085312 - were related to falls with injury

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that a resident's plan of care was based on their preferences.

Rationale and Summary
A complaint was received by the Ministry of Long Term Care (MLTC) related to multiple areas of care including meal service.

Registered Practical Nurse (RPN) #100 and Personal Support Worker (PSW) #101 indicated the resident preferred to eat their meal in a specific location. The resident's plan of care showed that their preferences were not included in the plan. The Administrator confirmed the plan of care should have been based on the resident's preferences.

Failure to include the resident's preferences in the plan of care placed the resident at risk of not having their needs met.

Sources: The resident's plan of care, interviews with PSW #101, RPN #101 and the administrator. [704757]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.

The licensee has failed to ensure that the plan of care for a resident was based of an interdisciplinary assessment of their sleep patterns and preferences.

Rationale and Summary
A complaint was received by the Ministry of Long Term Care (MLTC) in regards to resident #001's inability to rest at night.

A review of the resident's health records showed that no assessment of the resident's sleep patterns and preferences had been completed. The Behaviour Support Ontario (BSO) lead informed the inspector that a sleep assessment was required to be completed upon admission to determine their sleep patterns and preferences, and confirmed that no assessment was completed for the resident.

Failure to complete an interdisciplinary assessment of the resident's sleep pattern placed the resident at risk of inadequate rest and sleep during the night.

Sources: The resident's plan of care, and interview with the BSO lead.
[704757]