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

Public Report

Report Issue Date: March 14, 2025

Inspection Number: 2025-1164-0002

Inspection Type:
Critical Incident

Licensee: Chartwell Master Care LP

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11- 14, 2025

The following intake(s) were inspected:

- An Intake related to fall prevention

The following intakes were completed in this inspection:

- An Intake related to an Environmental Hazard
- An Intake related to Misuse/Misappropriation of resident's money, missing items

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.

Reports re critical incidents

s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) 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:

2. A description of the individuals involved in the incident, including,

ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at or discovered the fall incidents for a resident.

A review of the Critical Incident Report (CIR) submitted to the Director on an identified date did not include the staff members who were present at or discovered the fall incidents on the identified dates. The Director of Care (DOC) confirmed in this report they did not include the above-mentioned information.

Sources: CIR, home's investigation notes, interview with the DOC.

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