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: September 5, 2025
Inspection Number: 2025-1164-0005
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): September 3, 4, 5, 2025

The following intake(s) were inspected:

- Two Intakes related to the fall of the resident and sustaining an injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to implement an intervention recommended by the physiotherapist (PT) to support safe ambulation and reduce the risk of falls for a resident. The PT recommended one-person assistance when using a mobility device, the resident fell several times after this assessment. One fall was unwitnessed and resulted in injury requiring hospital transfer; others were witnessed with no indication of staff assistance.

The care plan was not updated to reflect the PT's recommendations. During an inspection, the resident was observed walking independently with a mobility device. The Personal Support Worker (PSW) confirmed that staff did not routinely assist the resident while walking. The PT and Assistant Director of Care (ADOC) stated the unit nurse was responsible for updating the care plan, but no changes had been made.

Sources: Resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary; or

The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised upon receiving advice from the external specialist.

The resident experienced a fall resulting in an injury. Prior to the fall, the resident ambulated using a mobility device. Following an external consultation, the resident was advised to begin ambulating without the use of a mobility device. Based on this recommendation, staff began discontinuing the use of the mobility device. However, an interview with the ADOC confirmed that any changes to a resident's care or mobility status based on external specialist advice must first be reviewed and approved by the home's physician and PT team, with corresponding updates made to the resident's care plan, and this was not followed for the resident.

Sources: The resident's clinical records and interview with ADOC.

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