Ontario

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

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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
Sep 12, 2013	2013_049143_0046	O-000325-13	Critical Incident System

Licensee/Titulaire de permis

CHARTWELL MASTER CARE LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET, AJAX, ON, L1S-1R9

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6th, 2013.

During the course of the inspection, the inspector(s) spoke with The Acting Administrator, the Nursing Consultant, a Registered Nurse, a resident and a family member.

During the course of the inspection, the inspector(s) reviewed a resident health care record inclusive of plan of care, progress notes, Community Care Access Centre assessments, fall assessments as well as fall policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Minimizing of Restraining

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. On a specified date the CCAC completed a resident application assessment for a Long Term Care Home placement within the MDS RAI 2.01 assessment tool for resident #1. This assessment indicated on page three of six that resident #1 was at high risks for falls. A reassessment was completed by the Community Care Access Centre on a specified date indicating that the resident had two falls within the last ninety days and that the resident was at risk for danger of falls. On a specified date resident #1 was admitted to the Long Term Care Home. On a specified date S105 (Registered Practical Nurse) completed the admission assessment within the home's electronic assessment tool (Point Click Care) and indicated no as the response to the falls assessment question, "does the resident have a history of falls". Resident #1 sustained a fall one day post admission resulting in an injury and transfer to hospital. The resident was hospitalized and returned to the Nursing Home five days post fall. A Critical Incident Report (#2658-000013-13) was submitted to the Ministry of Health and Long Term Care identifying that an injury had occurred that resulted in a transfer to hospital. S104(Registered Nurse) completed this report and documented on page 3 of 4 that the admission paperwork did not indicate any prior falls. A review of the homes falls policy (# LTCE-CNS-G-10) page 2 of 7, procedure one indicated that on admission Registered Staff will review the pre-admission assessment completed by the CCAC for indicated risks of falling.
The Licensee has failed to comply with Ontario Regulation 79/10 section 24.(4) by not ensuring that the admission care plan is based on the resident's assessed needs as provided by the placement co-ordinator. [s. 24. (4)]

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 that all 24-hour admission care plans include assessments and information provided by the placement co-ordiantor, to be implemented voluntarily.

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Issued on this 12th day of September, 2013

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