Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
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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
Jan 11, 2013	2013_049143_0003	0-002414-12	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): January 8-11th, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, the Acting Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) Reviewed health care records inclusive of fall assessments, progress notes, plan of care and observed resident care and services.

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

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On a specified date resident # 1 was observed sitting in their wheelchair without a fall prevention device in place. A review of the plan of care indicated that the resident #1 is at risk for falls and interventions include but are not limited to a fall prevention device on his/her bed as well on his/her wheelchair. On a specified date resident # 1 was observed sleeping in a raised bed. A fall prevention device was attached to the bed as well as two full side rails observed in the upright position. A review of the plan of care indicated that the resident is to have one side rail up and ensure bed is in the lowest position at all times.

The licensee has failed to comply with LTCHA s.6.(7) by not ensuring that the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Issued on this 11th day of January, 2013

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