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: April 25, 2024	
Inspection Number: 2024-1164-0001	
Inspection Type: Critical Incident	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Ballycliffe Long Term Care Residence, Ajax	
Lead Inspector Sheri Williams (741748)	**Inspector Digital Signature** Sheri A Williams Digitally signed by Sheri A Williams Date: 2024.04.26 14:57:46 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8, 9, 10, 11, 2024

The following intake(s) were inspected:

- Intake: #00111998 - 2658-000003-24 - ARI - Influenza A - Outbreak

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

Infection Prevention and Control
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Protection from Restraining

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

Non-compliance with: FLTCA, 2021, s. 34 (1) 5.

Protection from certain restraining

s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

The licensee failed to ensure that residents were not restrained by the use of locks, barriers or other devices from leaving or entering resident rooms.

Rationale and Summary

During a tour of the home it was observed that four resident rooms on a specified home area had retractable gates in use across their doorways. The gates could not be easily opened, and staff demonstrated that it required a person to turn a knob on one side of the gate in order to unlatch the gate on the opposite side. It was observed that there were residents inside the bedrooms with a gate engaged who did not have the ability to release the gate.

The home's policy titled "Physical Restraint" indicated that a physical device means an appliance or apparatus that limits or inhibits a resident's movement. A resident is not considered to be restrained using a physical device if the resident is able to release the restraint themselves physically and cognitively. The policy on restraints

lists a procedure to be followed to apply a restraint including written consent, safety interventions and documentation required when a resident is not able to release a restraint themselves.

A review of the written plans of care for the residents whose rooms were observed to have retractable gates, revealed that the gates were not identified as a restraint, nor did they have safety interventions in place for their use as a restraint

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) indicated that retractable gates were in use to stop wandering residents from entering the rooms with gates, and that most of the residents in these rooms could not physically or cognitively remove them on their own.

The Environmental Consultant acknowledged if a resident was able to unlock the retractable gate then it would not be considered as a restraint, and if a resident cannot unlock a gate it would be considered a restraint.

The Administrator acknowledged that the home's policy directs that physical devices that residents cannot remove would be considered as a restraint and should be in the care plan and consented by family.

Following the interview the Environmental Consultant approached the Inspector to report that the home had removed the retractable gates. The Administrator confirmed the retractable gates had been removed and replaced with yellow wander strips and mesh stop signs that would not restrict movement.

When the licensee implemented the use of retractable gates that restrained residents who did not have the ability remove them, this posed a safety risk that residents could become entrapped or injured when trying to exit the room.

Sources: Observations, "Physical Restraint" Policy, resident's clinical health records, interviews with PSW, RPN, Environmental Consultant and Administrator. [741748]