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: July 2, 2025

Inspection Number: 2025-1164-0004

Inspection Type:
Complaint
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): June 25-27, 2025 and July 2, 2025.
The inspection occurred offsite on the following date(s): June 30, 2025

The following intake(s) were inspected:
An intake related to a witnessed fall of a resident
An intake related to an unknown cause of injury to a resident.
An intake related to neglect of a resident.
An complaint intake related to physical abuse of a resident.

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The Licensee has failed to ensure a resident was not neglected. A Registered Practical Nurse (RPN) observed swelling and redness on the resident but did not conduct a pain assessment, communicate to the physician, or inform the oncoming shift nurse. The Director of Care (DOC) acknowledged this was a violation of the home's pain management program and the Residents' Bill of Rights. The resident was diagnosed with a fracture in hospital.

Sources: Critical Incident Report, home's pain management program- Policy #: LTC-ON-200-05-06; Revision date: July 2024, resident's clinical health records, home's investigation notes, Interviews with DOC.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives

concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure a written complaint related to the care of a resident was forwarded immediately to the Director. A written complaint was sent to the licensee related to a resident's personal care and alleged abuse of the resident. The incident was reported to the Director late, after the alleged abuse complaint was brought to the attention of the Director of Care (DOC) by a nurse.

Sources: Critical Incident Report, email correspondence, interviews with a nurse and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

A Registered Practical Nurse (RPN) was informed of alleged abuse by the family of a resident. The RPN sent an email about the abuse allegation to the DOC the next day, and this was submitted as alleged abuse to the Director. RPN acknowledged that they should have reported the allegation immediately.

Sources: Critical incident report, interviews with RPN and the DOC.

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