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: November 18, 2025
Inspection Number: 2025-1164-0007
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): October 29- 31, 2025, November 3-7, 10, 12-14, 17-18, 2025.

The following intake(s) were inspected:
A Intake regarding a fall of a resident with an injury.
A Intake regarding a fall of a resident with an injury.
A Intake regarding an allegation of physical abuse towards a resident by staff.
A Intake regarding a fall of a resident with an injury.
A Intake regarding a fall of a resident with an injury.

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

Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident sustained a fall which resulted in an injury. Staff did not collaborate by sharing assessments of the injured area and did not follow up to obtain results of tests post injury.

Sources: Critical Incident Report (CIR), a resident ’s clinical record, the home’s Skin and Wound Care Program, 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 (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.

1. There was no documentation indicating the registered staff collaborated with the interdisciplinary team to develop and implement a plan of care when the resident returned home from hospital on two occasions after receiving treatment for an injury.

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

2. A resident returned to the home from hospital without a discharge summary or follow up instructions after receiving assessment and treatment for a injury. There was no indication that attempts were made by staff to obtain a discharge summary or follow up instructions.

Sources: CIR, resident’s clinical records, interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The resident's clinical records indicated that care had been refused on numerous occasions. The Registered Practical Nurse (RPN) indicated the resident had preferences for care. The residents plan of care was not revised to include further interventions to meet the residents expressed care needs.

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

WRITTEN NOTIFICATION: Accommodation Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The resident plan of care related to interventions indicated a safety device. Observation of the resident's safety device indicated it was not working to alert staff that the resident required assistance. The RPN confirmed the safety device was not working at the time of the observation.

Sources: Observation, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The policy Abuse Allegation and Follow-up was not complied with when the resident did not receive a head to toe assessment after an allegation of abuse and when the investigation was completed there was no documentation indicating the results were reviewed with the Substitute Decision Maker (SDM) and resident.

Sources: Abuse Allegation and Follow-up policy, investigation notes, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

Observation indicated that a resident’s call bell was not easily seen and accessible. The RPN confirmed the resident call bell was not within the resident’s reach.

Sources: Observation, the residents clinic records, interview with staff.

WRITTEN NOTIFICATION: Bathing

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated

by a medical condition.

A resident required personal hygiene and required a linen change, the resident requested a bathing preference. Personal Support Worker (PSW) confirmed the resident was not given their preference.

Sources: Resident's clinical records, investigation notes, interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident's plan of care indicated the resident was to be transferred by a device. Observation indicated that the PSW transferred the resident without using the device. The RPN confirmed the resident was not transferred using the device when the resident was transferred from the bed.

Sources: Observation, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (2)
Personal items and personal aids
s. 41 (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids.

The resident 's written plan of care indicated that the resident required a personal aid and staff assistance to access the personal aid. On three separate days the resident was observed not to have the personal aid.

Sources: Resident's clinical record, observations, interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The Falls Prevention and Management Program was not followed when the Falls lead confirmed that resident had falls however the Falls committee did not meet the following month, to complete an analysis, identify trends and if required develop an action plan to make improvements to manage the resident's fall. The Fall's Lead further confirmed that based on the post falls analysis the resident's plan of care was not modified to include interventions to prevent repeat falls from occurring.

Sources: The Resident Fall Prevention Program, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Required programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (a)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(a) provide for screening protocols; and

A resident did not have an assessment completed at the time of a incident and prior to transfer to hospital. Upon return from hospital the next day, continuing assessments were indicated as per the home's flowsheet tool and the home's Resident Fall Prevention Program but were not completed. The home's Resident Fall Prevention Program indicated that an assessment was to be completed at the time of the incident and for a time period after.

Sources: CIR, resident's clinical record, home's Resident Fall Prevention Program, interview with staff.

WRITTEN NOTIFICATION: Required programs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

A resident was transferred to hospital for assessment and treatment of an injury. Reassessment using a specified tool was not completed upon the return from hospital as required by the Resident Fall Prevention Program when there was an injury or multiple falls. A resident sustained multiple falls during a one month period. The home's Resident Fall Prevention Program indicated that a resident's fall risk level will be reassessed with a fall with serious injury or multiple falls.

Sources: CIR, the resident's clinical record, home's Resident Fall Prevention Program, interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

A resident did not receive a skin and wound assessment using a clinically appropriate tool when they returned from hospital with altered skin integrity.

Sources: CIR, a resident's clinical record, home's Skin and Wound Policy, interview

with staff.

WRITTEN NOTIFICATION: Pain management

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident sustained a fall with an injury. The resident was initially treated with PRN (pro re nata – "as needed") analgesic medication for three days. The pain was not subsequently well controlled as a Comprehensive Pain Assessment was not completed to guide appropriate pain management until numerous days after the injury.

Sources: CIR, the resident 's clinical record, home's Pain Management Program, interview with staff.

WRITTEN NOTIFICATION: Laundry service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

Care staff in the home do not have consistent access to an adequate supply of towels and face clothes necessary for the provision of resident care.

Sources: Observations of the linen room on a home area, interviews with staff, review of home's Laundry Protocol.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A resident returned from hospital, with an injury. There was no CIR submitted to the Director upon the residents return from hospital and when there was a change in the resident's health condition.

Sources: CIR, the resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The staff confirmed that the resident was ordered an analgesic for pain management however the registered staff did not administer three doses of analgesic as it was not available.

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

COMPLIANCE ORDER CO #001 Required programs

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The Director of Care (DOC) or designate will review the home's Pain Management policy with all registered staff on a home are including but not limited to information on when pain assessments should be completed and where they should be documented.

2. The DOC or designate will provide scenario-based, interactive education to the registered staff on a home area related to assessment of pain and pain management provided to a resident after a fall sustained on a given date.

3. The DOC or designate will provide education regarding a resident's Pain Management to those registered staff working during a different home area. The education will include when the registered staff are to complete resident pain assessments and the types of pain assessments staff are to implement to manage a resident’s pain.

4. The DOC or designate will provide education to a Registered Nurse (RN) regarding completing a Comprehensive Pain assessment when a resident reports new pain.

5. Keep a documented record of the staff’s education, who was educated, the date of the education, and who provided the education.

Grounds

1. The Pain Management Program was not followed to manage a resident's pain. A resident sustained a fall which resulted in a injury. A Comprehensive Pain Assessment was not completed for pain related to the injuries and ongoing pain monitoring until the results of a test were received numerous days later. As pain assessments were not completed, appropriate pain management was not provided.

Sources: CIR, the resident's clinical record, home's Pain Management Program, interview with staff.

2. The Pain Management Program was not followed to manage a resident's pain. A Comprehensive Pain Assessment was not completed when the resident reported new pain. The DOC confirmed that when the resident reported new pain a Comprehensive Pain Assessment was to be completed by the registered staff. There was an increased risk when the resident reported new pain and there was no Comprehensive Pain Assessment completed as the resident's pain may have been unmanaged.

Sources: Pain Management Program, email correspondence, interview with staff.

3. The Pain Management Program was not followed when the registered staff indicated the resident had a high pain score and there was no documentation indicating the registered staff reassessed the effectiveness of the intervention. There was no documentation by the registered staff that they followed up and assessed the resident's pain when the PSW's documented on multiple occasions the resident had pain. Documentation of the resident's Comprehensive Pain Assessments indicated there were incomplete Comprehensive Pain Assessments. A staff confirmed that there was no reassessment of the resident's pain, there were incomplete Comprehensive Pain Assessment's, and there was no pain assessments by the registered staff on several occasions when the PSW's documented the resident had pain. There was an increased risk to the resident's emotional, physical well being and quality of life when the resident's pain was not assessed and reassessed by the registered staff.

Sources: Pain Management Program, the resident's clinical records and a interview with staff.

This order must be complied with by January 30, 2026

COMPLIANCE ORDER CO #002 Plan of care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The RAI Coordinator or designate along with registered staff will review two resident's written plan of care to ensure the content provides clear direction to staff who provide care.

2. Keep a documented record of the resident's reviewed and revised plans of care, the names of the staff that participated in the review, and the date of the review.

Grounds

1. A staff confirmed that a resident's plan of care indicated they were to be transferred using a device. The staff further confirmed the resident's plan of care did not provide clear directions regarding the residents toilet transfer, toilet use, and the mobility, walking adaptative aids. When the plan of care did not provide clear direction to staff the resident was at an increased risk of injury.

Sources: the residents clinical records, interview with staff.

2. The resident's written plan of care provided inconsistent direction to staff regarding the resident's ambulatory status and their ability to request assistance. Two adaptative aids were in the resident's room which increased the risk of injury to the resident since staff were unsure of which mobility device the resident was to use. The care plan also indicated that the resident should use the call bell to request assistance. The resident did not have the ability to use the call bell and ambulated on their own, which resulted in unclear direction to staff and increased risk of injury.

Sources: CIR, the resident's clinical record, interviews with staff.

This order must be complied with by January 30, 2026

COMPLIANCE ORDER CO #003 Skin and wound care

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The DOC or designate will provide education to two RN's on completing a clinically appropriate instrument when a resident has altered skin integrity.

2. The DOC or designate will review the home's Resident Fall Prevention Program and the Skin and Wound Program with all registered staff on one of the home areas. Scenario-based, interactive education will be provided to all registered staff related to the fall of a resident on a given date with a focus on the requirement for skin and wound assessment following injury and when a resident is experiencing ongoing pain.

3. The DOC or designate will review the home's Skin and Wound Program with all PSW staff on the one of the home areas with a focus on the requirement and importance of ongoing skin assessments by PSW staff. Scenario-based, interactive education will be provided to PSW staff related to the fall of the resident on a given date, and the importance of on-going skin assessments after a resident has sustained a fall.

4. Keep a documented record of the education provided, the date, who provided the education and signatures of the staff that the education was provided to.

Grounds

1. A resident demonstrated changes to their skin integrity along with ongoing complaints of pain, after sustaining a fall. The resident did not receive a skin and wound evaluation by registered staff until numerous days after they sustained the injury. Lack of a skin

and wound evaluation put the resident at risk of receiving inadequate pain management as staff were not aware of the resident's extent of the pain the resident was experiencing in relation to the injury.

Sources: CIR, the resident's clinical record, home's Skin and Wound Care Program, interview with staff.

2. On two occasions the resident's clinical records indicated the registered staff documented the resident had altered skin integrity. The staff confirmed when the registered staff noted altered skin integrity they were to complete a skin and wound assessment using a clinically appropriate tool. The staff confirmed that staff did not use a clinically appropriate instrument, on either occasion. When the registered staff did not complete a assessment of the resident's altered skin integrity using a clinically appropriate instrument the resident may have been at an increased risk of obtaining appropriate treatment.

Sources: Skin and Wound Program, the residents clinical records, interview with staff.

3. A Resident sustained a fall that resulted in a injury. A skin and wound assessment was not immediately completed after the resident sustained the injury.

Sources: CIR, the resident 's clinical record, home's Skin and Wound Program, interview with staff.

This order must be complied with by January 30, 2026

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.