Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 21, 2022
Inspection Number 2022_1164_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
Chartwell Master Care LP

Long-Term Care Home and City
Chartwell Ballycliffe Long Term Care, Ajax

Lead Inspector
Susan Semeredy (501)

Inspector Digital Signature

Additional Inspector(s)
Britney Bartley (732787)

Inspector Sheri Williams (741748) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 14, 15, 16, 17, 20, 22, 23, 24, 2022.

The following intake(s) were inspected:

- Intake # 021224-21 related to resident-to-resident physical abuse
- Intake # 000033-22 related to staff-to-resident physical abuse
- Intake # 011416-21 related to bed refusal of a resident
- Intake # 009641-21 related to wound care, personal care, call bell and dietary concerns
- Intake # 009458-22 related to palliative care and skin and wound

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

- Admission, Absences & Discharge
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Palliative Care
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours

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- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6(5).

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary:

Resident #001 was admitted to the home with advanced medical conditions. The physician had a discussion with the SDM and the SDM decided for palliative care and if the resident was unable to take pain medications orally then such medications would be administered subcutaneously. The family continued to visit daily and feed the resident. At some point they were surprised when they noticed the resident was being given medications subcutaneously. Progress notes indicated for the most part the resident was not in pain and was eating well. There was no indication in the resident's medical record that the family was informed when there was this change of medication administration.

An interview with a Registered Practical Nurse (RPN) indicated the resident's family had not been informed of this change and the family was shocked and upset. The RPN further indicated that it is not common practice in the home to make such a change without consent from the family and they were only aware of the resident being in pain when being repositioned. The RPN also confirmed the family visited every day and the resident ate well in their presence.

According to skin assessments and progress notes, resident #001 developed altered skin integrity and the family was notified when this was first discovered. The wound deteriorated quickly. Progress notes and skin assessments did not indicate the SDM was informed that the wound was deteriorating. The SDM was shocked to find out the extent of the wound.

An interview with a Nurse Practitioner indicated that when they treated the wound they were not in contact with the family as the home usually informs the family of their recommendations. An interview with the physician indicated that they did not inform the family of the status of the wound as this is something that nursing would usually do.

The DOC acknowledged that the expectation of the home is to keep the SDM informed of the resident's change in status and medication administration.

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Failing to give an opportunity for the SDM to participate fully in the development and implementation of resident #001's plan of care caused the SDM to have distrust with the care being provided.

Sources: Resident #001's medical record including progress notes, skin and pain assessments; Interviews with an RPN and other staff members.
[501]

COMPLIANCE ORDER [CO#001] [PREVENTION OF ABUSE AND NEGLECT]

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 19(1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007 s.19(1): Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The home shall:

1. Ensure resident #005 is protected from physical abuse from resident #004.

2. Ensure all direct care staff are retrained on the home's prevention of abuse policy with an emphasis on the therapeutic relationship between care giver and resident and how to manage residents demonstrating responsive behaviours towards them. Document the contents of this education as well as the date, those providing and receiving the education.

Grounds

Non-compliance with: LTCHA, 2007 s. 19 (1)

1. The licensee has failed to ensure that resident #005 was protected from physical abuse from resident #004.

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Section 2 of the Ontario Regulation 79/10 defined physical abuse as any form of physical force by anyone that causes physical injury or pain.

Rationale and Summary

A Personal Support Worker (PSW) was in the hallway when they witnessed resident #005 approach resident #004. Resident #004 got up from their assistive aide and pushed resident #005. Resident #005 fell and was sent to the hospital with an injury.

During an interview with the PSW they noted the incident happened quickly and they immediately went to assess both residents. Further diagnostic tests and an interview with the DOC confirmed resident #005 sustained injuries. Failing to protect the resident from abuse resulted in actual harm to resident #005.

Sources: Review of a Critical Incident System (CIS) report and resident #004 and #005's clinical health records; interviews with a PSW and the DOC.

2. The licensee has failed to ensure a resident was protected from physical abuse from a PSW.

Rationale and Summary

An RN overheard an argument between a PSW and a resident and quickly went to assess the situation. Upon their arrival they witnessed the PSW holding a device and even though the RN told them to put it down, the PSW then hit the resident causing a skin alteration. The RN immediately reported this to the DOC. The home notified the police and the family members of the incident. The PSW no longer works at the home.

Failing to protect the resident from physical abuse resulted in injury to the resident.

Sources: Review of a CIS report, the resident's clinical health record, home's investigation notes and interviews with the RN and DOC. [732789]

This order must be complied with by September 30, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.