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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: July 3, 2025
Inspection Number: 2025-1086-0004
Inspection Type: Critical Incident
Licensee: Chartwell Master Care LP
Long Term Care Home and City: Chartwell Gibson Long Term Care Residence, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-27, 30, July 2 and 3, 2025.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00143931/ CI #2556-000007-25 was related to an allegation of abuse.
- Intake: #00149486/ CI #2556-000012-25 was related to a disease outbreak.
- Intake: #00150238/ CI #2556-000013-25 was related to breakdown of a major equipment in the home.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #001 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 licensee has failed to ensure that Registered Nurses (RN) complied with the home's written policy to promote zero tolerance of abuse and neglect.

The home's policy instructed staff to conduct a resident assessment following an incident of suspected abuse. However, a RN did not assess a resident following such incident. The assessment was completed by a different RN three days later.

The policy also required staff to report such incidents immediately to the Executive Director (ED), Director of Care (DOC), or their supervisor and the same was not done by the RNs.

Sources: Home's policy # LTC-ON-100-05-02 titled Abuse Allegation and Follow-up (revised July 2024), the home's investigation notes and interviews with interviews with staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 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 an incident of suspected abuse of a resident was reported to the Director immediately, as required. The report was submitted three days later.

Sources: Resident's clinical records, review of CI #2556-000007-25 and the home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with. Specifically, to ensure proper use of personal protective equipment (PPE), including appropriate application of PPE in accordance with the IPAC Standard as required by Additional Precaution 9.1(d) under the Standard.

On a certain day, a Personal Support Worker (PSW) was observed exiting a resident's room without wearing the required gown and gloves after providing the resident assistance. The resident was under droplet and contact precautions at the time.

Sources: Observations, review of "IPAC Standard for Long-Term Care Homes, revised September 2023", interviews with staff.

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