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: August 25, 2025

Inspection Number: 2025-1086-0005

Inspection Type:
Critical Incident
Follow up

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): August 6-8, 11-13, 14, 19, 2025.

The inspection occurred offsite on the following date(s): August 15, 20-21, 2025.

The following intakes were inspected in this Follow Up inspection:

- Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) - Duty to protect from Inspection #2025-1086-0003

- Follow-up #: 1 - FLTCA, 2021 - s. 28 (1) - Reporting certain matters to the Director from inspection #2025-1086-0003

- Follow-up #: 1 - FLTCA, 2021 - s. 25 (1) - Policy to promote zero tolerance from inspection #2025-1086-0003

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake: #00152687/ CI #2556-000014-25 related to a missing resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1086-0003 related to FLTCA, 2021, s. 24 (1)
Order #003 from Inspection #2025-1086-0003 related to FLTCA, 2021, s. 28 (1)
Order #002 from Inspection #2025-1086-0003 related to FLTCA, 2021, s. 25 (1)

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Reporting and Complaints

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 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan for a resident related to their safety.

A resident required a specific intervention for their safety to be included in their plan of care and communicated to specific staff in the Long-Term Care Home (LTCH). The registered staff and the Director of Care (DOC) stated that the identified staff was not aware of this specific safety intervention, as a result, it was not implemented.

Sources: Review of the resident's clinical records, and interviews with a registered staff and DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit, and implement a plan to ensure that the home can care for residents who require specific safety interventions. This plan must include, but is not limited to:

1) Create a plan to ensure all registered staff are trained on completing the required assessments, including identifying when the assessment is indicated, any applicable referrals to be made, how to conduct the assessment, where to document, and what should be included in their documentation.

2) How the home will ensure safety checks are completed accurately to maintain resident safety on the first floor.

3) Create a plan on how to educate identified staff on how residents are offered their nourishments/snack and how to complete the respective documentation.

Grounds

The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

In accordance with the definition identified in Ontario Regulation 246/22 section 7, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

i. A resident's care plan indicated that the resident was to be assessed on a regular basis. Assessments for the resident were not completed as per care plan for a specified time. Staff indicated that they did not know how to complete the required assessments and had never completed one for the resident.

ii. A resident's care plan indicated the resident required safety checks. On a specified day, safety checks were not completed or accurately documented for the resident for a period of time.
The failure of staff to complete the required assessments and conduct timely safety checks, significantly increased the risk of inadequate supervision and delayed intervention, and thereby elevated the resident's risk to their safety.

Sources: Review of the resident's care plan, documentation survey report, progress notes, assessments, investigation notes, and interviews with staff.

This order must be complied with by October 6, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Previous CO ordered to the same legislative reference on May 09, 2025 in inspection #2025-1086-0003.

This is the first AMP that has been issued to the licensee for failing to comply with this

requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.