

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

Original Public Report

Report Issue Date: November 28, 2023	
Inspection Number: 2023-1086-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Gibson Long Term Care Residence, North York	
Lead Inspector Susan Semeredy (501)	Inspector Digital Signature
Additional Inspector(s) Manish Patel (740841) Michael Chan (000708)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 9, 10, 14, 15, 16, 17, 20, 21, 2023

The following intake(s) were inspected:

- Intake: #00101161 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management

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

Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.

Posting of information

s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:

10. The current version of the visitor policy made under section 267.

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

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary

On November 9, 2023, during an initial tour of the home, the visitor policy was not observed to be posted. The Administrator and Director of Care (DOC) acknowledged that this policy was not posted in the home.

On November 10, 2023, the visitor policy was confirmed posted at the front desk, front entrance and on Residents' and Family Councils boards on the ground floor.

Sources: Observations and interviews with the Administrator and DOC. [740841]

Date Remedy Implemented: November 10, 2023

WRITTEN NOTIFICATION: Residents' Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 17.

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:

17. Every resident has the right to be told both who is responsible for and who is providing the resident's direct care.

The licensee has failed to ensure a resident's right to be to be told who was providing the resident's direct care was fully respected and promoted.

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

Rationale and Summary

A resident indicated they were upset that a Personal Support Worker (PSW) whom they had never met came to provide care. The resident's care plan indicated that if their regular staff was not coming, the resident would prefer a regular registered staff to tell them who would provide the care and introduce the staff member.

A PSW who had never provided care to the resident previously, confirmed they were not introduced to the resident before going to provide care. A Registered Practical Nurse (RPN) who was the regular staff on duty that day, indicated they did not introduce this PSW to the resident.

Failing to respect a resident's wishes regarding new staff approaching them to provide care, put the resident's well-being at risk.

Sources: A resident's care plan and interviews with the resident, a PSW and an RPN. [501]

WRITTEN NOTIFICATION: Quality

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (4)

Resident and Family/Caregiver Experience Survey
Advice

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

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

The licensee has failed to ensure that advice was sought from the Residents' Council in carrying out the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

The Residents' Council meeting minutes indicated, that for the 2023 Resident and Family/Caregiver Experience Survey, the home had not reviewed the survey with the Residents' Council to determine if there were areas for input. The Administrator stated that the survey was conducted by an external group and the residents did not get an opportunity to make changes.

Sources: Residents' Council meeting minutes for 2023, and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Quality

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (5) (c)

Resident and Family/Caregiver Experience Survey

Documentation

s. 43 (5) The licensee shall ensure that,

(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

The licensee has failed to ensure that the results of the Resident and Family/Caregiver Experience Survey, as well as, the actions taken to improve the long-term care home were made available to families.

Rationale and Summary

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

The Administrator stated that the results of the Resident and Family/Caregiver Experience Survey were posted in the basement outside the Main Dining Room. However, posting of this information was not observed anywhere else in the home for families. The Administrator also indicated that the families had not been informed via a newsletter of the above information.

Sources: Observations and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Family Council

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

Non-compliance with: FLTCA, 2021, s. 65 (7) (b)

Family Council

Licensee obligations if no Family Council

s. 65 (7) If there is no Family Council, the licensee shall,

(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure semi-annual meetings were convened to advise persons of the right to establish a Family Council when there was no Family Council.

Rationale and Summary

The home's newsletters indicated the home did not have a Family Council and were hoping to establish one. The Administrator confirmed the home has not convened semi-annual meetings to advise families of the right to establish a Family Council since the pandemic.

Sources: The home's newsletters and an interview with the Administrator. [501]

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

WRITTEN NOTIFICATION: Operation of Homes

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

Retraining

s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that the persons who have received training in the home's policy to promote zero tolerance of abuse and neglect received retraining annually.

Rationale and Summary

An interview with a PSW indicated that they were unsure when they last completed training on the home's policy to promote zero tolerance of abuse and neglect of residents. According to the Administrator, the last time this PSW received such training was over a year ago.

The home's training records from October 31, 2022, to October 31, 2023, indicated that 23% of staff had not received this retraining. The Administrator was unable to verify the exact number as some of the total number of staff were on leaves of absences. However, they acknowledged that not all staff had been retrained annually on this subject as was their expectation.

Failing to ensure all staff completed annual retraining on abuse and neglect put

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

residents at risk of harm.

Sources: Training records and interviews with a PSW and the Administrator. [501]

WRITTEN NOTIFICATION: Directives By Minister

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

Directives by Minister

Binding on licensees

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure the home carried out every operational or policy directive that applied to the long-term care home (LTCH).

Rationale and Summary

Section 1.2 of the Minister's Directive, states that LTCHs are required to ensure that masking requirements as set out in the MLTC COVID-19 Guidance are followed. As of November 2, 2023, the COVID-19 Guidance Document for Long-term Care Homes in Ontario states that masks are required to be worn in all resident areas indoors by staff, students, volunteers, and support workers.

A staff member was observed in the hallway with their mask below their nose and face. The staff member stated that they had a problem with wearing the mask. The Administrator indicated that the staff member should have let them know so that

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

they could be provided a solution and confirmed that a mask should be worn by all staff in resident areas.

Section 2 of the Minister's Directive, states that licensees of LTCHs are required to ensure that the PPE requirements as set out in COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings Version 11 last revised June 26, 2023, are followed. This document indicates that when interacting within two metres of residents in a COVID-19 outbreak area, recommended PPE includes appropriate eye protection (goggles, face shield, or safety glasses with side protection).

Another staff member was observed coming out of a COVID-19 positive room that had appropriate signage and was not wearing any eye protection. They indicated that they knew they should have worn a face shield but had forgotten and proceeded to put one on. An RPN and the Administrator confirmed the staff member should have been wearing eye protection.

Staff failing to wear the appropriate PPE put others at risk for infectious disease, including, COVID-19.

Sources: Observations, the Ministers' Directive and interviews with the Administrator and other staff. [501]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

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

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure a resident who required assistance with eating was served a meal before someone was available to assist.

Rationale and Summary

A resident was observed sitting in the dining room with an entrée of food in front of them. The resident was not eating, and no staff were assisting them. When staff did come to assist several minutes later, the resident was not interested in eating.

The resident's care plan stated that they required assistive with eating. According to a PSW, this was a table that registered staff were supposed to assist with feeding. An RPN who was from an agency, was unaware that they needed to assist with feeding at this table. The Administrator confirmed that staff need to be ready to assist with eating before a meal is served to them, as it needs to be at the proper temperature.

Failing to provide assistance with eating when served a meal put the resident's nutritional status at risk.

Sources: Observation, a resident's care plan, and interviews with an RPN and other staff. [501]

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

WRITTEN NOTIFICATION: Quality

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

5. The home's registered dietitian.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee included the home's registered dietitian.

Rationale and Summary

The Administrator and Education and Quality Improvement Coordinator described the home's CQI committee as being a combination of the Leadership Team and the Professional Advisory Committee in which the home's registered dietitian was not a member.

Sources: Interviews with the Administrator and Education and Quality Improvement Coordinator. [501]

WRITTEN NOTIFICATION: Quality

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

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

8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the CQI committee included a Personal Support Worker (PSW).

Rationale and Summary

The Administrator and Education and Quality Improvement Coordinator described the home's CQI committee as being a combination of the Leadership Team and the Professional Advisory Committee in which a PSW was not a member.

Sources: Interviews with the Administrator and Education and Quality Improvement Coordinator. [501]

WRITTEN NOTIFICATION: Quality

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

9. One member of the home's Residents' Council.

The licensee has failed to ensure that the CQI committee included a member of the home's Residents' Council.

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

Rationale and Summary

The Administrator and Education and Quality Improvement Coordinator described the home's CQI committee as being a combination of the Leadership Team and the Professional Advisory Committee in which a member of the home's Residents' Council was not included.

Sources: Interviews with the Administrator and Education and Quality Improvement Coordinator.[501]

WRITTEN NOTIFICATION: Quality

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 4.

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

The licensee has failed to ensure that the CQI report included a written description of a process to communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

Rationale and Summary

The CQI report found on the home's website was reviewed. The Administrator confirmed that the home's CQI report did not include how the home would

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

communicate outcomes for their priority areas.

Sources: The home's CQI report and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Quality

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

5. A written record of,

iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the home's CQI report included how, and the dates when, the results of the Resident and Family/Caregiver Experience Survey were communicated to the residents and their families, Residents' Council, and members of the staff of the home.

Rationale and Summary

The CQI report found on the home's website was reviewed. The Administrator confirmed that the CQI report did not include the above information.

Sources: The home's CQI report and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Quality

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

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. iv.

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

The licensee has failed to ensure that the CQI report included the role of the CQI committee in their actions taken to improve the long-term care home and that these actions were based on the documentation of the results of the Resident and Family/Caregiver Experience Survey, and the home's priority areas for quality improvement.

Rationale and Summary

The CQI report found on the home's website was reviewed. The Administrator confirmed that the CQI report did not include the above information.

Sources: The home's CQI report and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Quality

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following

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

information:

6. A written record of,
 - v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the CQI report included how, and the dates when, the actions taken to improve the long-term care home were communicated to residents and their families, the Residents' Council and members of the staff of the home.

Rationale and Summary

The CQI report found on the home's website was reviewed. The Administrator confirmed that the CQI report did not include the above information.

Sources: The home's CQI report and an interview with the Administrator. [501]

WRITTEN NOTIFICATION: Quality

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (3)

Continuous quality improvement initiative report

s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the CQI report was provided to the

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

Residents' Council (RC).

Rationale and Summary

RC meeting minutes were reviewed from March 23, 2022 to November 17, 2023, and there was no evidence that the Council received a copy of the home's CQI report. The Administrator confirmed that the RC was not given a copy of this report.

Sources: RC meeting minutes and an interview with the Administrator. [501]