

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: August 29, 2025
Inspection Number: 2025-1061-0006
Inspection Type: Complaint Critical Incident
Licensee: Kindera Living Care Centres LP by its general partners, Kindera Living Care Centres GP Inc. and Kindera Living Management Inc.
Long Term Care Home and City: Banwell Gardens Care Centre, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26, 27, 28, 29, 2025

The following intake(s) were inspected:

Intake #00154442/CI #2263-000049-25 related to a respiratory outbreak.

Intake #00155151/CI #2263-000052-25 related to alleged abuse.

Intake #00154523 related to a complaint regarding alleged abuse and resident rights.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Residents' Rights and Choices

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that a resident received the correct diet texture after changes to their plan of care had been made.

Sources: Long-Term Care Home's Investigation Interview notes, resident's clinical records, and staff interview.

WRITTEN NOTIFICATION: Infection Prevention and Control

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee failed to ensure that the presence of infection was monitored and

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documented, on every shift, for two residents who were actively exhibiting symptoms of infection.

Sources: The residents' clinical records, the home's infection surveillance policy, and staff interviews.