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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: January 13, 2025

Inspection Number: 2024-1023-0004

Inspection Type:
Critical Incident
Follow Up

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: Wellington Park Care Centre, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 13, 16-17 & 19, 2024

The following intake(s) were inspected in the Critical Incident (CI) section:
Intake: #00123199/CI #1023-000018-24 - relating to sexual abuse of a resident
Intake: #00127146/CI #1023-000019-24 - relating to falls prevention and management

Intake: #00124322 - Follow-up #1 - Compliance Order (CO) from inspection 2024-1023-0002 relating to O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2024-1023-0002 related to O. Reg. 246/22, s. 102 (2) (b)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a falls intervention in place for a resident was documented.

Rationale and Summary
An intervention in the plan of care for a resident, was not documented in Point Click Care (POC) once a shift as per the plan of care required.

During an interview with the DOC, they acknowledged that the intervention was in place for the resident but the intervention was not documented because it was not added to the POC.

Failure to ensure that the intervention was documented does not allow for assessment of the resident's response to the intervention.

Sources: Plan of care, interview with staff. **[741771]**

WRITTEN NOTIFICATION: Plan of care

NC #002 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 has failed to ensure that care set out in the plan of care was provided to a resident.

Rationale and Summary
A staff provided a shower to a resident without the assistance of a second staff. The resident's plan of care indicated that the resident requires two staff to complete a shower.

DOC confirmed that the staff did not follow the resident's plan of care and that they should have.

Failure to follow the resident's plan of care could have posed a risk to resident's safety.

Sources: A resident's clinical records, investigation notes, interview with the DOC. **[000763]**