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

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Public Report

Report Issue Date: February 19, 2025
Inspection Number: 2025-1073-0001
Inspection Type: 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: Eatonville Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11, 12, 14, 18, and 19, 2025
The inspection occurred offsite on the following date(s): February 13, and 19, 2025

The following intake(s) were inspected:

- Intake: #00133437 / Critical Incident (CI) #2468-000062-24 was related to the outbreak of a communicable disease.
- Intake: #00136179 / CI #2468-000001-25 was related to fall of resident resulting in injury.

The following intake(s) were completed:

- Intake: #00133409 / CI #2468-000063-24 and Intake: #00133999 / CI #2468-000066-24 were related to fall of resident resulting in injury.
- Intake: #00138808 / CI #2468-000005-25 was related to the outbreak of a communicable disease.

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

Infection Prevention and Control
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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care, collaborated with each other in the completion of a diagnostic procedure.

A resident had a fall, and was observed limping and complaining of pain. A diagnostic procedure was ordered, and it was not completed until a period of seven days. The resident continued to ambulate and experienced pain during this time, and further assessment was not carried out.

Sources: Resident's clinical records, interviews with RPN, ADOC, and other staff.

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 failed to ensure that a resident had an intervention as specified in their plan of care during an observation. The resident was at risk for falls and required a specific intervention to mitigate the risk of falls.

Sources: Resident's clinical records, the resident observations, interviews with Registered Nurse (RN), and ADOC.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and their care plan was reviewed and revised when their falls prevention and management interventions were ineffective after the resident sustained two falls.

Sources: Resident's clinical records, interview with RPN, RN, ADOC, and other staff.