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: April 15, 2025
Inspection Number: 2025-1073-0002
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 dates: April 1-4, 7-11, 14-15, 2025
The inspection occurred offsite on the following date: April 11, 2025

The following Critical Incident (CI) intakes were inspected:
Intake: #00139037 - [CI: #2468-000008-25] - related to neglect of a resident
Intake: #00139248 - [CI: #2468-000009-25] - related to improper care of a resident
Intake: #00139487 - [CI: #2468-000010-25] - related to staff to resident abuse
Intake: #00139973 - [CI: #2468-000014-25] - related to fall with injury
Intake: #00143085 - [CI: #2468-000021-25] - related to an infectious disease outbreak

The following CI intakes were completed:
Intake: #00139867 - [CI: #2468-000011-25] and Intake: #00143538 - [CI: #2468-000022-25] - related to infectious disease outbreaks

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

Resident Care and Support Services

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
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 (4) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in a resident's care collaborated in the development and implementation of the resident's plan of care.

During the resident's annual physical assessment on a specified date, a physician identified a health concern and ordered a diagnostic test. On the resident's following annual assessment, the physician identified the same health concern.

A Registered Nurse (RN) acknowledged they missed following up on the resident's diagnostic test referral until their following annual assessment. As a result, the resident did not receive the diagnostic test until over one year later.

Sources: Resident's clinical records; and interview with the RN.

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 a resident was provided with the level of assistance specified in their care plan. The resident's plan of care indicated they required a specific level of assistance with their activities of daily living (ADL), however a Personal Support Worker (PSW) did not provide the required assistance to the resident.

Sources: Resident's clinical records, home's investigation notes; and interview with the PSW.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was protected from physical abuse by a PSW.

In accordance with the definition identified in Ontario Regulation 246/22 section 2,

"physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

During care, a resident exhibited responsive behaviours, following which a PSW used physical force to intervene. Subsequently, the resident displayed signs of discomfort and other negative effects.

Sources: Resident's clinical records, home's investigation notes; and interviews with the PSW, RPN, and ADOC.

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that all doors leading to stairways were kept secure, when some residents had the access code to multiple stairways and other areas of the home. The Environmental Services Manager (ESM) and Executive Director (ED) acknowledged the purpose of the keypad code was to restrict resident access to the stairwells and the residents should not have had access to the stairway code.

Sources: Observations; home's policy "RCS E-130-01 Resident Safety - Security of Doors", the home's access codes; and interviews with the ESM and ED.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas, including the fire alarm system door and telephone room door in the basement were kept closed and locked when they were not supervised by staff on two occasions. The ESM and ED confirmed these doors should have been closed and locked as residents had access to the basement.

Sources: Observations; Home's policy "RCS E-130-01 Resident Safety - Security of Doors"; and interviews with the ESM and ED.

WRITTEN NOTIFICATION: Elevators

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 13
Elevators
s. 13. Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

The licensee has failed to ensure that elevators in the home restricted resident

access to non-resident areas, when the elevator access code provided to multiple residents also gave them unrestricted access to non-resident areas, including the basement. On an identified date, a resident was observed to be unsupervised in the basement. The ESM and ED confirmed this practice allowed for unsupervised access to the basement's non-resident areas, which could pose safety risks to the residents.

Sources: Observations; Home's policy "RCS E-130-01 Resident Safety - Security of Doors"; and interviews with the ESM and ED.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that falls prevention devices were readily available at the home. A RN identified a specific device as a falls prevention intervention for a resident. The Assistant Director of Care (ADOC) stated that the falls prevention device was not readily available, and was later purchased and implemented for the resident several days after.

Sources: Resident's progress notes; and interviews with the RN and ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

Staff were required to wear surgical masks on an outbreak unit. However, two staff members were observed without surgical masks while on the outbreak unit.

Sources: Observations; and Interviews with the staff and IPAC Lead.