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: April 9, 2025

Inspection Number: 2025-1050-0002

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: Cooksville Care Centre, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 7 - 9, 2025.

The following intake(s) were inspected:

- Intake: #00139332 - Critical Incident (CI) 2124-000004-25 - related to infection prevention and control.

The following intake(s) were completed:

- Intake: #00133768 - CI 2124-000054-24 - related to infection prevention and control;
- Intake: #00139992 - CI 2124-000005-25 - related to infection prevention and control.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

IPAC Standard for Long Term Care Homes, revised September 2023, stated under section 9.1 that Routine Precautions were to be followed in the IPAC program, which included (b) hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact). Two staff members failed to perform hand hygiene both before and after assisting several residents with meal service prior to helping others.

Sources: Observations of meal service and interview with IPAC Lead.