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
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Public Report

Report Issue Date: June 5, 2025
Inspection Number: 2025-1050-0003
Inspection Type: Complaint
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): May 26-27, 29-30, 2025 and June 2-5, 2025
The inspection occurred offsite on the following date(s): May 28, 2025

The following intake(s) were inspected:
Intake: #00143198 - Complaint related to Food, Nutrition and Hydration, Resident Care and Services, Medication Administration, and Laundry Services.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care was revised when their care needs changed related to an infection and level of assistance required for eating.

A) A resident was experiencing symptoms of infection and their plan of care was not revised to include the infection until five days later. The plan of care was also not revised when the isolation precautions were discontinued. The Nurse Consultant identified the precautions were discontinued, however, the care plan strategies were not resolved until eight days later, and progress notes did not identify when isolation had been discontinued.

The resident later required additional precautions. The additional precautions were discontinued, however, the written plan of care was not resolved until 26 days later. It was unclear when the precautions were discontinued.

Sources: clinical health record for the resident; interview with staff.

B) A resident's plan of care was not revised to reflect an increased need for feeding assistance after a decline in condition. The plan identified the resident was

independent with eating, however, staff routinely documented the provision of extensive to full assistance with eating at meals during the same period.

Sources: clinical health record for a resident; interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to implement their medication administration policy when a staff was observed pre-pouring and administering medications to multiple residents. The home's medication administration policy specifies that medication administration is to be completed for one resident at a time.

Sources: observations of medication administration; Manual for MediSystem Serviced Homes, August 2024, Medication Administration, General; interview with staff.