

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: July 9, 2025

Inspection Number: 2025-1050-0004

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 dates: June 24-27, 30, and July 2-4, 7-9, 2025

The following intake(s) were inspected:

- Intake: #00144524 - Critical Incident (CI) related to prevention of abuse and neglect.
- Intake: #00145714 - CI related to falls prevention and management.
- Intake: #00145760 - CI related to safe and secure home.
- Intake: #00145790 - CI related to resident care and support services.
- Intake: #00146116 - CI related to falls prevention and management
- Intake: #00148970 - CI related to safe and secure home.

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

Resident Care and Support Services
Safe and Secure Home
Prevention of Abuse and Neglect

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Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

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

A) The licensee has failed to ensure that a resident's plan of care was reviewed and revised when a specified intervention was no longer necessary. The intervention was observed on a specified date. A Clinical Director of Care (CDOC) acknowledged that the intervention was discontinued and removed the specified intervention immediately.

Sources: Observations, a resident's clinical records, and interview with a CDOC and staff.

Date Remedy Implemented: June 26, 2025

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B) The licensee has failed to ensure that a resident's plan of care was reviewed and revised to reflect their current care needs. A registered staff confirmed that the resident had a specified intervention that was later discontinued and was no longer required, however this change was not updated in the resident's plan of care. The plan of care was subsequently updated.

Sources: A resident's clinical records and interview with the staff.

Date Remedy Implemented: July 2, 2025

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 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 staff and others collaborated effectively to support the integrated and consistent implementation of specific behavioral and personal care needs.

On two occasions, a particular item of concern was discovered among a resident's personal effects. A registered staff member confirmed that collaboration with the attending physician regarding the resident's use of the particular item was not established or implemented until a later date. The Director of Care (DOC) acknowledged that the home's established procedures were not followed.

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Sources: A resident's clinical records, home's policy and procedures for Resident Consumption of Alcohol, and staff interviews.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 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's plan of care regarding a specified falls prevention intervention was followed. The DOC stated that a registered staff present at the time of a fall reported the resident did not have the recommended specified intervention in use.

Sources: A resident's clinical notes, Home's investigation notes, and interview with DOC.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

19. Safety risks.

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The licensee failed to ensure that the resident's plan of care was informed by an interdisciplinary assessment of safety risks, specifically in relation to absences from the home. On an identified date, the resident demonstrated exit-seeking behaviour and left the premises without following the established sign-out procedure. Documentation showed that prior to the identified date, the resident's plan of care did not include an assessment or interventions related to the risk of unauthorized absence. The attending physician confirmed that they had not been made aware of emerging indicators that would have warranted a reassessment of the resident's safety risks.

Sources: A resident's clinical records, home's policy and procedures for Leave of Absence (LOA), and staff interviews.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident's specified responsive behaviours. On an identified date, after a resident's specified intervention was removed and alternative measures of a time-limited safety check monitoring period was implemented by a Behavioural Supports Ontario (BSO) Lead, further follow-up strategies were not developed or implemented.

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Sources: A resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 7.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

7. An incident of severe hypoglycemia or unresponsive hypoglycemia in respect of which a resident is taken to hospital. O. Reg. 246/22, s. 115 (3); O. Reg. 66/23, s. 24.

The licensee has failed to ensure that the Director was informed no later than one business day of a resident's incident of unresponsive hypoglycemia which resulted in a transfer to hospital on an identified date. The DOC acknowledged that a CI was reported late and was submitted more than one business day.

Sources: CI, CI Summary and Debrief, and interview with the DOC.

WRITTEN NOTIFICATION: Emergency plans

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. viii.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,
viii. situations involving a missing resident,

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The licensee has failed to comply with their emergency plan for situations involving a missing resident. On an identified date, a resident did not return to the home at the expected time indicated by the resident. A registered staff failed to attempt to locate the missing resident, notify staff and initiate a search as per the home's emergency plan.

Sources: A resident's clinical records, home's policy and procedures for Code Yellow - Missing Resident - General, home's investigation notes, and staff interviews.