

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: December 11, 2025
Inspection Number: 2025-1050-0006
Inspection Type: Complaint 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): November 27-28, and December 1-5, 8- 9, and 11, 2025.
The inspection occurred offsite on the following date(s): December 10, 2025.

The following intake(s) were inspected:

- Intake: #00156198 was related to Resident Care and Support Services.
- Intake: #00156696 was related to Infection Prevention and Control (IPAC).
- Intake: #00158763 was related to Prevention of Abuse and Neglect.
- Intake: #00161657 was related to Prevention of Abuse and Neglect.
- Intake: #00161695 was related to Falls Prevention and Management.
- Intake: #00161732 was related to Resident Care and Support Services.
- Intake: #00162197 was related to Resident Care and Support Services.
- Intake: #00162718 was related to Housekeeping, Laundry, and Maintenance Services.

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

- Resident Care and Support Services
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

(a) Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date, a resident applied physical force on another resident, causing physical injuries.

Sources: Review of Critical Incident System (CIS) report, two residents' records; and interviews with staff.

(b) Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date, a resident applied physical force on another resident which caused the resident to sustain an injury.

Sources: Review of CIS report, two residents' records, the home's investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 27 (6)

24-hour admission care plan

s. 27 (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 246/22, s. 27 (6).

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A resident who was at risk for falls, required a device for an activity of daily living. On an identified date, the resident was provided a different device than what was in their plan of care, and had a fall which led to an injury.

Sources: Review of a resident's records, investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

An alteration in a resident's skin integrity was discovered on an identified date. There was no skin assessment in Point Click Care (PCC) completed, when the altered skin integrity was reported to the nurse.

Sources: Review of a resident's records, the home's investigation notes; and interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

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

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

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A resident who had a history of responsive behaviours towards other residents, did not have interventions identified in their plan of care to minimize the risk of altercations with other residents. On an identified date, the resident exhibited responsive behaviours towards another resident which caused the other resident to fall.

Sources: Review of CIS report, two residents' records, home's investigation notes; and interview with staff.