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

Toronto District
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Public Report

Report Issue Date: July 3, 2025
Inspection Number: 2025-1100-0002
Inspection Type: Complaint Critical Incident Follow up
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: Hawthorne Place Care Centre, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24 to 27, 2025 and July 3, 2025
The inspection occurred offsite on the following date(s): July 2, 2025

The following intake(s) were inspected:

- Intake: #00144946 - Critical Incident System (CIS) 2586-000014-25 - related to Outbreak Management
- Intake: #00145272 - Follow-up - related to Infection Prevention and Control
- Intake: #00145545 - CIS #2586-000016-25 - related to Fall Prevention and Management
- Intake: #00149658 - Complaint - related to Resident Care and Support Services, Reporting and Complaints

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1100-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
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.

The licensee has failed to ensure a resident was not neglected by staff.

Ontario Regulation (O. Reg.) 246/22 s. 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or pattern of inaction that jeopardizes the health, safety and wellbeing of one or more residents.

i) A resident rang the call bell for assistance with continence care. While their primary Personal Support Worker (PSW) was providing care to another resident, no other staff member responded to the resident's call. The resident waited a long period of time to receive continence

care.

ii) On multiple occasions in an identified month, staff did not attend to a resident's request for assistance after they rang the call bell. The call bell report revealed significant delays in staff response times.

Sources: Complaint intake, review of a resident ’s clinical notes; call bell report, and interviews with the PSW, Director of Care (DOC) and other staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that written complaints sent to the home concerning the care of a resident were investigated and resolved where possible, and a response was provided within 10 business days.

A resident's Power of Attorney (POA) submitted a written complaint to the Executive Director

(ED) outlining care concerns. The ED confirmed that the home missed the initial meeting that was scheduled, and that there was no further communication with the POA about the meeting until three weeks later.

Sources: Review of complainant emails, a resident's clinical records, Client Service Response Form Policy, and interview with the ED.