

## 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**

5700 Yonge Street, 5th Floor Toronto, ON, M2M 4K5 Telephone: (866) 311-8002

## **Public Report**

Report Issue Date: November 13, 2025

**Inspection Number:** 2025-1100-0005

**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: Hawthorne Place Care Centre, North York

## **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): November 4 - 7, 10, 12 and 13, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00158812, CIS #2586-000050-25 related to fall prevention and management.
- Intake: #00160682, CIS #2586-000052-25 related to fall prevention and management.
- Intake: #00160758, CIS #2586-000053-25 related to fall prevention and management.

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

Falls Prevention and Management

#### **INSPECTION RESULTS**

### **WRITTEN NOTIFICATION: Plan of Care**

NC #001 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



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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.

Registered staff members did not collaborate with other staff members to implement an intervention related to a resident's injury following a fall.

**Sources**: Observations, resident's health records, interviews with staff members.

# WRITTEN NOTIFICATION: Transferring and Positioning Techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident was lifted manually by staff members following a fall incident that resulted in a change in their health status, though the home had a no-lift policy.

**Sources:** CIS report, home's policy, resident's clinical records; interviews with staff members.