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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: March 6, 2025
Inspection Number: 2025-1414-0002
Inspection Type: Critical Incident
Licensee: Kindera Living Care Centres GP Inc.
Long Term Care Home and City: Arbour Creek Long-Term Care Centre, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 3 - 6, 2025

The following intake(s) were inspected in the Critical Incident (CI) section:

- Intake: #00135007/ CI #2930-000061-24 - related to prevention of abuse and neglect
- Intake: #00135825/ CI# 2930-000062-24 - related to falls prevention and management.

The following intake was also completed during the inspection:

- Intake: #00138433/ CI# 2930-000005-25 - related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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 a resident's plan of care was complied with when an equipment was applied as observed on a date in March which the resident had refused on a previous date.

On a date in March, the DOC indicated that the resident had provided consent to the equipment.

Sources: Resident's clinical records, interviews with staff and observations.

Date Remedy Implemented: March 6, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital

status, family status or disability.

The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect. On a date in December 2024, a staff provided improper treatment to a resident in the dining room that resulted in the resident feeling upset.

Sources: Investigation notes, CI #2930-000061-24 and interview with resident.

WRITTEN NOTIFICATION: Based on assessment of resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure a resident's plan of care indicated to keep a specific equipment inaccessible to them as the resident would use this to put another equipment at a higher position.

Sources: Resident's clinical records and interview with staff.

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