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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 15, 2025
Original Report Issue Date: September 8, 2025
Inspection Number: 2025-1414-0006 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Kindera Living Care Centres GP Inc.
Long Term Care Home and City: Arbour Creek Long-Term Care Centre, Hamilton

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct intake number 0014953 to 00149536 in the inspection summary section.

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INSPECTION SUMMARY

The inspection occurred on-site on the following dates: August 27-28, 2025 and September 2-5, 8, 2025.

The following critical incident (CI) intakes were inspected:
- Intake 00149536/ CI 2930-000036-25 was related to fall prevention and management
- Intake 00153653/ CI 2930-000042-25 was related to prevention of abuse and neglect

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The following complaint intake was inspected:
- Intake 00154699 was related to prevention of abuse and neglect

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

AMENDED 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 failed to ensure that care set out in the plan of care was provided as

specified for a resident related to call bell accessibility. Staff corrected the call bell placement shortly after it was observed by the Inspector as inaccessible.

Sources: Observations, resident's clinical record.

Date Remedy Implemented: September 4, 2025

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 failed to ensure care was provided to a resident as set out in their plan of care when staff did not transfer the resident in accordance with direction set out in their plan.

Sources: Resident observation, resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
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:
5. Mood and behaviour patterns, including wandering, any identified responsive

behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to ensure a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of their mood and behaviour patterns, potential behavioural triggers and variations in their functioning at different times of the day. The resident demonstrated a specified responsive behaviour toward staff. A responsive behaviour assessment tool was completed, identifying multiple behavioural triggers and strategies to prevent and manage the behaviours. This information was not incorporated into the resident's care plan as required by policy.

Sources: Resident's clinical record, responsive behaviour policy, interviews with staff and management.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee failed to ensure that matters referred to in subsection (1) were integrated into the care provided to a resident. Specifically, a responsive behaviour assessment tool was not completed following multiple responsive behaviour incidents. Further, the resident's plan of care was not updated post-incident with preventative interventions.

Sources: Resident's clinical record, responsive behaviour policy, interviews with staff and management.