

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 3, 2025

Inspection Number: 2025-1414-0008

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 dates: November 18-20, 24, 26-27, and December 1-2, 2025.

The following intakes were inspected:

- Intake #00157770 was related to the prevention of abuse and neglect
- Intake #00158110 was related to infection prevention and control
- Intake #00162208 was related to infection prevention and control

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect

INSPECTION RESULTS

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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: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

In accordance with the Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, the home was required to ensure that alcohol based hand rubs must not be expired. An alcohol based hand rub was found to be expired and was then replaced.

Sources: Observations, the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, and interviews with staff.

Date Remedy Implemented: November 20, 2025

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident;

A resident's plan of care provided unclear directions in regards to the residents physical abilities and transfer needs.

Sources: The resident's clinical records and interviews with the resident and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A resident was found with a skin impairment who made allegations of abuse. The home reported the incident to the Director the day after being made aware of the incident.

Sources: The critical incident report, the resident's clinical records, and interviews with the resident and staff.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the pain management program were complied with. Specifically, the program indicated that a specific pain assessment was to be completed when an incident of physical abuse arises. This was not completed for a resident who made allegations of physical abuse until two months after the alleged incident.

Sources: The resident's clinical records and assessments, the home's pain management policy, and interviews with the resident and staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Additional Requirement 4.3 under the Infection Prevention and

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Control (IPAC) Standard for Long-Term Care Homes, the home did not create a summary of findings that made recommendations to the licensee for improvements to outbreak management practices for a declared outbreak.

Sources: The home's outbreak debrief notes, the IPAC Standard (April 2022, revised September 2023), and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home was declared in an outbreak of a disease of public health significance and did not report it to the Director until the following day.

Sources: The critical incident report, the home's outbreak notes and interviews with staff.