

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: January 19, 2026
Inspection Number: 2025-1414-0009
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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 2, 5-9, and 19, 2026.

The following intake(s) were inspected:

Intake: #00163594 -Critical incident related to improper or incompetent care of a resident.

Intake: #00165407 -Complaint related to improper or incompetent care of resident.

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

Resident Care and Support Services

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 (1) (c)

Plan of care

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; and

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a) A resident's clinical record indicated that they were experiencing symptoms of a medical condition but the plan of care did not include parameters for this.

b) A resident's clinical record indicated that the resident had a fever for multiple days but there was no clear direction on how and when to treat.

Sources: Resident's clinical record, infection prevention and control policy, interviews with staff and Director of care (DOC).

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) 5.

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:

5. Every resident has the right to freedom from neglect by the licensee and staff.

Section 2 of the Ontario Regulation (O. Reg.) 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents."

A resident had symptoms of a medical condition but their condition was not treated on multiple occasions until the substitute decision maker (SDM) brought it to the nurse's attention.

Sources: Resident's clinical record, interviews with staff and SDM.