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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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Public Report

Report Issue Date: February 11, 2025
Inspection Number: 2025-1061-0001
Inspection Type: Proactive Compliance Inspection
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: Banwell Gardens Care Centre, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 4-7, 10-11, 2025

The following intake(s) were inspected:

- Intake: #00138410 related to Proactive Compliance Inspection 2025

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management
Skin and Wound Prevention and Management
Resident Care and Support Services

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

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 (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

The Licensee failed to ensure that clear directions were provided to the staff for assisting a resident with transfers and toileting, when the transfer logo indicated a different type of transfer than the interventions reflected in the care plan. During an observation, it was noted that the transfer logo indicated a different type of transfer than it was specified in the care plan. On the same day, the RAI Coordinator confirmed with the inspector that the logo was changed to mirror the interventions in the care plan and that staff were informed of the change.

Sources: resident's clinical record and interviews with staff.
Date Remedy Implemented: February 10, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The Licensee failed to ensure that residents-staff communication and response system in the front lobby was not functioning, therefore not accessible to the residents and staff.
During an observation it was found that the residents-staff communication and response system in the front lobby of the building was not functional. There was no audible signal and no staff member responded for a determined period of time after the call bell cord was pulled. During a later observation by the inspector, the residents-staff communication and response system was working, and its signal was audible.

Sources: observations and communication with staff.
Date Remedy Implemented: February 4, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) 000833]controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the

locked medication cart.

The licensee failed to ensure that controlled substances were stored in a double-locked stationary cupboard when two separate storage areas were observed. In one hallway medication room, there was a double locked wooden box for storage of controlled substances that were to be destroyed, that was not stationary and in the refrigerator there was a small box with one lock that was not stationary and contained a certain amount of controlled substances.
The double locked wooden box was bolted down which had made it stationary and the small locked refrigerated box was moved the to another hall medication room into a stationary double locked refrigerator.

Sources: Observation of one hallway medication room and staff interviews.
Date Remedy Implemented: February 5, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b)
Drug destruction and disposal
s. 148 (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.
O. Reg. 246/22, s. 148 (3); O. Reg. 66/23, s. 31.

The licensee failed to ensure that non-controlled medications were destroyed by a team of two acting together; one registered staff and one staff appointed by the Director of Care (DOC). Two Registered Practical Nurses (RPNs) and Assistant Director of Care (ADOC) had indicated that non-controlled medications were placed into a pail for destruction by one staff acting alone.

ADOC had provided documentation relating to non-controlled medication destruction requiring two staff and one on one education had been provided to all staff on shift and would be completed for all registered staff.

Sources: The Long-Term Care Home's (LTCH) policy and staff interviews .
Date Remedy Implemented: February 5, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #005 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

The licensee has failed to ensure the plan of care of a resident provided clear directions to the staff regarding the resident's wheelchair physical device. The Executive Director indicated that the resident's care plan did not identify the process for the use of the resident's wheelchair physical device.

Sources: resident's care plan and interview with Executive Director

WRITTEN NOTIFICATION: Residents' Council

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

Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The Licensee failed to ensure that a response was provided to the Residents' Council when the home was advised of concerns related to the cleaning of the windows in the building.

Sources: review of Residents' Council Meeting Agenda/Minutes and interview with staff.

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