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
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Public Report

Report Issue Date: February 5, 2025
Inspection Number: 2025-1077-0001
Inspection Type: Critical Incident Follow up
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: Orchard Terrace Care Centre, Stoney Creek

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28 - 31, 2025 and February 3, 5, 2025.

The following intake(s) were inspected:

The following intakes were completed in this Critical Intake inspection:

- Intake #00130709 - Critical Incident (CI) related to falls prevention and management.
- Intake #00130833 - CI related to prevention of abuse and neglect.
- Intake: #00132688 - Follow Up related to duty of licensee to comply with plan.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1077-0003 related to FLTCA, 2021, s. 6 (7)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from physical abuse by another resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, it was documented that a resident had a physical altercation with a co-resident that resulted in an injury.

Sources: Resident clinical records, CI, interview with staff and resident.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to identify behavioural triggers for a resident who was being monitored for physical responsive behaviours. During review of the charting from over a seven day period, incomplete documentation was noted on five days.

Sources: Resident clinical records, CI, interview with staff.