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
Telephone: (800) 663-3775

Public Report

Report Issue Date: January 16, 2025

Inspection Number: 2025-1084-0001

Inspection Type:
Critical Incident

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: Berkshire Care Centre, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 14 - 16, 2025

The following intake(s) were inspected:

- Intake: #00131834 - Critical Incident (CI) #2541-000047-24 - Relating to an allegation of improper/incompetent treatment of a resident.
- Intake: #00131903 - CI #2541-000048-24 - Relating to falls prevention and management.
- Intake: #00133512 - CI #2541-000053-24- Relating to resident to resident responsive behaviours.
- Intake: #00134156 - CI #2541-000055-24 - Relating to medications.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a staff member used safe transferring techniques when assisting a resident.

A resident was transferred via a transferring device with only one staff, when two staff were required and the resident fell during the transfer and as a result sustained a fracture.

Sources: Resident clinical records, investigation notes, Policy "Mechanical Lifts and slings" last revised June 17, 2024.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that a Head Injury Routine (HIR) was implemented for a resident when they were struck in the head by another resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed to reduce the risk of harm are complied with.
According to the LTC home's policy titled, Head Injury Routine (HIR), the resident required head injury monitoring.

Sources: Resident clinical records, Head Injury Routine (HIR) policy, interview with an RPN.