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
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London, ON, N6A 5R2
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Public Report

Report Issue Date: March 27, 2025

Inspection Number: 2025-1084-0003

Inspection Type:
Complaint
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 dates: March 19 - 21, March 24 - 27, 2025

The following intakes were inspected:

- Intake: #00140151 - complaint related to alleged neglect
- Intake: #00140165 / Critical Incident (CI) 2541-000005-25 - related to alleged neglect
- Intake: #00141590 / CI 2541-000007-25 - related to alleged neglect
- Intake: #00142504 / CI 2541-000011-25 - related to alleged abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessment, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure a staff member collaborated with a registered staff member when a resident displayed a change in their health status. Specifically, the staff member acknowledged they failed to inform a registered staff member when a resident's health declined, resulting in the resident being transferred to the hospital.

Sources: a resident's progress notes, physician's order sheets, Critical Incident (CI) investigation notes, interview with a staff member

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's provision of care set out in the plan of care was followed. Specifically, a staff member confirmed they did not do an intervention that was identified in the care plan.

Sources: Interviews with staff members, CI investigation notes.

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.

The licensee failed to ensure that the Director was immediately notified of an incident of abuse between two residents.

Sources: Critical Incident Report #2541-000011-25, interview with staff members