

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: February 11, 2026

Inspection Number: 2026-1073-0001

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: Eatonville Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-6 and 9-11, 2026

The following intakes were completed in this Critical Incident (CI) inspection:

Intake: #00165966 (CI #2468-000061-25) was related to infection prevention and control.

Intake: #00168103 (CI # 2468-000001-26) was related to a residents' care and services.

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

Resident Care and Support Services
Infection Prevention and Control

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 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different

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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.

A resident returned from the hospital with a device in place. A staff member received the information that the device was to remain in place. A staff member removed the device without collaborating with the medical team with respect to the recommendation.

Sources: CI report, resident clinical records, home's investigation notes; and interviews with relevant staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's Power of Attorney (POA) was not provided an opportunity to participate in the implementation of the resident's plan of care. A staff member did not obtain consent from the resident's POA prior to initiating the orders from the physician.

Sources: Resident clinical records, home's investigation notes; and interviews with relevant staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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