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

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

Public Report

Report Issue Date: September 5, 2025
Inspection Number: 2025-1073-0004
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: Eatonville Care Centre, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 25, 26, 28, 29, 2025 and September 2 - 5, 2025.

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00150881, CIS #2468-000035-25 related to fall resulting in injury.
- Intake: #00151708, CIS #2468-000037-25 related to care concerns of a resident.

The following Complaint Intake was inspected:

- Intake: #00152025 related to care concerns of a resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

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) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff members collaborated with each other in the assessment of a resident, as the registered staff was not initially notified of the resident's change in condition.

Sources: Resident's clinical record, home's investigation notes; interviews with staff members.

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 the care set out in the plan of care was provided to a resident as specified in their plan of care. The resident required a device to be applied at all times to reduce the risk of injury and on a specific day, the device was not applied and they sustained an injury.

Sources: Resident’s clinical records and interviews with staff members.

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 has failed to ensure that an incident of alleged staff to resident neglect that had occurred was immediately reported.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act, and pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

Staff did not immediately report the allegation of neglect to the Director.

Sources: Resident's clinical records and interview with a staff member.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 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 they transferred a resident, despite the resident’s plan of care requiring a specific level of assistance from staff.

Sources: Resident’s clinical records; interviews with staff members.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to develop and implement strategies to manage a resident's responsive behaviour.

A resident exhibited a responsive behaviour on a specified date, however no strategies had been developed or implemented to address this responsive behaviour. On a later date, the resident exhibited the same responsive behaviour which led to a negative health outcome

Sources: Residents' health records, interviews with staff members.