

**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:** October 15, 2025

**Inspection Number:** 2025-1073-0005

**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): October 7-10, 14, 15, 2025.

The following intake(s) were inspected:

- ▯ Intake: #00155537 Critical Incident (CI) #2468-000048-25 was related to a fall of a resident with injury.
- ▯ Intake: #00158069 CI #2468-000054-25 was related to a communicable disease.
- ▯ Intake #00159197 CI #2468-000058-25 was related to a communicable disease.
- ▯ Intake: #00158911 CI #2468-000057-25 - was related to alleged improper care of a resident.

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

Resident Care and Support Services  
Infection Prevention and Control  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**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 care plan.

A resident's care planned fall prevention intervention noted a safety device was to be applied as per their plan of care. The resident had an unwitnessed fall. A Registered Practical Nurse (RPN) indicated that the safety device was not implemented as per their plan of care. The Associate Director of Care (ADOC) acknowledged as per the resident's plan of care the safety device was to be implemented.

**Sources:** A resident's clinical records, the home's investigation file, interviews with a RPN and the ADOC.