

Public Report

Report Issue Date: September 24, 2025

Inspection Number: 2025-1048-0006

Inspection Type:

Critical Incident

Follow up

Licensee: Poranganel Holdings Limited

Long Term Care Home and City: King City Lodge Nursing Home, King City

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23, 24, 2025

The following intake(s) were inspected:

- One intake related to Follow-up #: 1 - CO #002, 2025-1048-0004, O. Reg. 246/22 - s. 356 (3), Construction, renovation, etc., of homes, CDD: September 9, 2025, and
- One intake related to a fall of resident with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1048-0004 related to O. Reg. 246/22, s. 356 (3)

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

Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

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

Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that staff reviewed a resident's care plan, which resulted in injury.

The resident's plan of care indicated that the resident was required to have one staff to assist while ambulating.

At the time of the fall, the Personal Support Worker (PSW), confirmed they did not review the resident's care plan prior to providing care and was not aware that they were required to stay with the resident during ambulation.

Sources: Critical Incident Report, resident's Progress Notes, interviews with a Registered Nurse (RN) and Director of Clinical Care and Quality.

WRITTEN NOTIFICATION: Reports re critical incidents

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

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee had failed to ensure that the Director was informed no later than one business day after a resident fell, sustained an injury, transferred to hospital, and resulted in a significant change.



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Sources: CIR, and interviews with the Director of Clinical Care and Quality, resident's clinical chart.



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