

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

Public Report

Report Issue Date: April 2, 2026
Inspection Number: 2026-1048-0002
Inspection Type: Critical Incident
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): March 31, April 1, and 2, 2026.

The following intake(s) were inspected:
Intake related to an unexpected death of a resident

Inspection Manager was present as an observer during this inspection.

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Collaboration

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

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A resident was noted to be ill and deteriorated throughout the day and the physician was not informed of the residents change in status.

Registered nurses (RNs) and the Director of Clinical and Quality (DOCQ) indicated the home did not collaborated with the physician when the resident's health status changed.

Sources: Critical Incident System (CIS) report, resident's health records, and interviews with RNs and DOCQ.

WRITTEN NOTIFICATION: Reporting to the Director

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

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The home submitted the CIS report later when a resident sustained a medical event.

Sources: CIS report and residents health records.

WRITTEN NOTIFICATION: Informing SDM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (6)

Reports re critical incidents

s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

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A resident was noted to be ill and deteriorated throughout the day. The resident's Substitute Decision-Maker (SDM) was not informed of the change in health status and that the resident had passing.

RNs and the DOCQ the SDM was not called immediately.

Sources: CIS report, resident's health records, and interviews with RNs and DOCQ.



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

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