Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2020	2020_832604_0009	013545-20	Critical Incident System

Licensee/Titulaire de permis

Poranganel Holdings Limited
2231 Medhat Drive MISSISSAUGA ON L5B 2E3

Long-Term Care Home/Foyer de soins de longue durée

King City Lodge Nursing Home
146 Fog Road King City ON L7B 1A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 19, 20, & 21, 2020.

During the course of the inspection an intake related to a fall was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Manager (NM), Associate Nurse Manager (ANM), Registered Nurse (RN), and Personal Support Worker (PSW).

During the course of the inspection the inspector reviewed resident health records, staff to resident interaction, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when the care set out in the plan had not been effective as it related to residents falls.

A review of the residents' care plan indicated they were at increased risk of falls and included interventions. During the review of the care plans it was noted that no new approaches were considered in the revision of the plan of care when the resident fell. In separate interviews the Nurse Manager (NM) and Associate Nurse Manager (ANM) confirmed the care set out in the residents' care plan was not effective and different approaches were not considered which put the resident at greater risk for falls.

Sources: Critical Incident Report (CIS) report, resident care plan, progress notes, and interviews with Nurse Manager (NM), Associate Nurse Manager (ANM), Registered Nurse (RN), and Personal Support Worker (PSW).

2. A review of a second residents' care plan indicated they were at increased risk of falls and included interventions. During the review of the care plans it was noted that no new approaches were considered in the revision of the care plan when the resident fell. In separate interviews the NM and ANM confirmed the care set out in the residents' care plan was not effective and different approaches were not considered which put the resident at greater risk for falls.

Sources: resident care plan, progress notes, and interviews with NM and ANM.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that different approaches were considered in the revision of the plan of care when the care set out in the plan had not been effective as it related to residents falls., to be implemented voluntarily.

Issued on this 29th day of October, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.