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

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

Original Public Report

Report Issue Date: May 3, 2024	
Inspection Number: 2024-1048-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Poranganel Holdings Limited	
Long Term Care Home and City: King City Lodge Nursing Home, King City	
Lead Inspector Vernon Abellera (741751)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23 to 26, 2024.

The following intake(s) were inspected:

-One complaint intake related to food production and preparation.
-One Intake related to an outbreak.

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

Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that resident's symptoms indicating the presence of infection were recorded on every shift.

Rationale and Summary

The inspector had reviewed the 'monthly Infection Control Tracking Tool form' for the entire home, which identified residents with infections. The resident had been noted to have an infection. Treatment had been prescribed for several days. According to the resident's progress notes, their infectious symptoms had not been monitored and recorded for several shifts until the completion of the treatment. There had been no documentation for 14 consecutive shifts.

The Infection Prevention and Control (IPAC) lead confirmed that the resident's symptoms should have been monitored and recorded on every shift during this time period.

Failing to monitor and record residents' infectious symptoms every shift may hinder staff from monitoring residents and their response to treatment.

Sources: Resident's Clinical record and interview with the IPAC lead [741751]

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 (1) 5.
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):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of two respiratory outbreaks.

Rationale and Summary

A respiratory outbreak was declared at the home on two separate occasions by the Public Health Unit (PHU). The two outbreaks were not reported to the Director immediately.

The Director of Nursing and Personal Care (DONPC) stated that the outbreaks were not reported to the Director as required.

By not reporting the two respiratory outbreaks to the Director immediately, the Director was unable to respond to the incidents in a timely manner.

Sources: critical incident system reports and interviews with DONPC [741751]