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
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Original Public Report

Report Issue Date: January 29, 2024	
Inspection Number: 2023-1048-0002	
Inspection Type: Critical Incident	
Licensee: Poranganel Holdings Limited	
Long Term Care Home and City: King City Lodge Nursing Home, King City	
Lead Inspector Diane Brown (110)	**Inspector Digital Signature** Diane Brown Digitally signed by Diane Brown Date: 2024.01.29 13:25:32 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 8, 12, 14, 15, 18, 2023.

The following intake(s) were inspected:
Intake: #00005682 - related to a fall resulting in an injury.
Intake: #00090727 - related to a loss of essential services (water).

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

Safe and Secure Home
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.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that resident #001's written plan of care set out clear directions, related to toileting, to staff and others who provide direct care to the resident.

Summary and Rationale

A Critical Incident (CI) was reported to the Director regarding resident #001's fall that resulted in a significant health change.

Resident #001's fall resulted in an injury and the associated treatment impacted the resident's mobility. The written care plan was updated with a transfer intervention to reflect the resident's mobility change. The toileting focus identified the resident's need for a one person physical assistance however the urinary incontinence focus stated to not use the toileting device related to the resident's health status.

Personal Support Worker (PSW) #108 assisted resident #001 into the washroom and transferred them onto the toilet. The resident fell while in the washroom.

The Director of Clinical Care and Quality (DCCQ) who had updated the plan of care after the resident's prior fall confirmed that the written plan of care was unclear as to how the resident was to be toileted at the time of the CI reported fall.

The failure to provide clear direction to PSW providing care placed the resident at risk of improper care and may have contributed to the resident's reported fall that resulted in a significant injury.

Sources: Resident's clinical record and care plan. interviews with PSW #108 and the Director of Clinical Care and Quality. [110]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

Summary and Rationale

A CI was reported to the Director regarding resident #001's fall resulting in a

significant change of health status.

The resident's health record revealed they had prior falls with significant changes in their health status leading up to the CI reported fall inspected. The Director of Clinical Care and Quality confirmed the resident's pattern of falls and shared that physiotherapy (PT) referrals were generated after each fall. Hard copy referrals, located in the "PT referral binder", were reviewed by the Inspector. Three PT referrals were identified, two after a fall and one for further assessment and treatment of the resident's injuries. The three referrals were prior to the CI reported fall being inspected. A review of progress notes along with the Director of Clinical Care and Quality failed to identify any documentation by the PT in response to the referrals. The resident's plan of care related to physiotherapy had not been updated for over a year, further revealing the PT referrals had not been addressed.

The PT confirmed the lack of a response to the three referrals and with no associated documented assessments.

Failure of the PT to respond to the referrals placed resident #001 at risk of pain and may have contributed to the series of falls resulting in significant injury.

Sources: Resident's clinical record and care plan. PT referral binder and referrals, interviews with PT and the Director of Clinical Care and Quality. [110]