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

Public Report

Report Issue Date: June 16, 2025
Inspection Number: 2025-1048-0004
Inspection Type: Complaint 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): June 9-11, June 13, and June 16, 2025
The inspection occurred offsite on the following date(s): June 12, 2025
The following intake(s) were inspected:

- An intake related to the alleged abuse of a resident by a staff member
- An intake related to a complaint regarding the home's physical environment

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Ontario Regulation 246/22 states that physical abuse is "the use of physical force by anyone other than a resident that causes physical injury or pain." The regulation states that emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

A resident was handled “roughly” during care provided by a Personal Support Worker (PSW). Altered skin integrity was identified following the incident and the resident was reported to experience emotional distress.

Sources: Health records for a resident, Internal Form, Employee File, Home’s Policy on Abuse and Neglect, Interviews with a PSW, the Director of Clinical Care and Quality, and the home’s Administrator.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee had reasonable grounds to suspect that an alleged incident of abuse of a resident by a staff member that resulted in harm or a risk of harm to the resident had occurred. A PSW was first informed of the alleged incident and failed to report it to registered staff and management of the home at that time. Once the home's management was informed, there was an additional delay in reporting, as the Administrator indicated that the home wished to complete the investigation prior to reporting. The Critical Incident Report (CIR) was submitted on a specific date, following the home's internal investigation. The Director of Clinical Care and Quality and the Administrator both indicated that the report should have been made immediately.

Sources: Critical Incident Report, interviews with a PSW, the Director of Clinical Care and Quality, and the home's Administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A resident was identified as exhibiting altered skin integrity on a specified date. The resident did not receive a skin assessment by an authorized person, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The altered skin integrity was identified by a physician, however, there were no images captured of the altered skin integrity, no skin and wound evaluation tools completed by a registered staff or the physician, and there were no subsequent weekly evaluations completed.

Sources: Health records for a resident and interview with the Director of Clinical Care and Quality.

WRITTEN NOTIFICATION: Maintenance Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (a)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

During the course of the inspection, the premises were found to be in a state of disrepair, exhibiting multiple unresolved maintenance deficiencies, including but not limited to roof deterioration and evidence of water infiltration affecting both the exterior and interior of the facility. The inspector sought clarification regarding the home's maintenance schedule. Through staff interviews and a review of relevant documentation, it was confirmed that maintenance personnel are scheduled to be on-site exclusively during regular business hours, specifically Monday through Friday, from 9:00 AM to 5:00 PM.

Sources: Observations, record review, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

On a specified date, the inspector observed images of residents with snakes draped around the residents' necks. The Life Enrichment Coordinator was unaware of risks associated with reptiles and has failed to engage the IPAC lead in policy review.

Sources: Resident observation and an interview with staff.

WRITTEN NOTIFICATION: Evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (e)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The licensee has failed to ensure that a written record was promptly prepared in relation to the following: evaluation of the effectiveness of the Licensee's policy under section 25 of the Act (including changes and improvements required to prevent further occurrences) at least once per calendar year, that changes/improvements are promptly implemented, and evaluation details such as the date of evaluation, names of persons who participated in the evaluation, and the date that changes/improvements were implemented. The home's Administrator reported that evaluation is conducted informally and there are no specific records prepared.

Sources: The Home's Policy on Abuse and Neglect and interview with the Administrator.

COMPLIANCE ORDER CO #001 Accommodation services

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The Administrator or designate will develop a tool or method to evaluate the state of repair of all resident home areas, including but not limited to corridors, resident rooms, resident washrooms, shower rooms, dining areas, and activity rooms, and exterior of the building including the roof, facade and eavestroughs and downspouts.

2. Once areas requiring maintenance services have been identified, such as roofing, ceiling, light fixtures, bathroom fixtures, windows, walls, baseboards, floors, countertops, and furnishings, the home must:
    1. Develop an action plan categorizing the identified items into three groups:
        1. Items that can be repaired immediately.
        2. Items that can be repaired within 1-4 weeks.
        3. Items requiring more than 4 weeks to repair.
    2. Specify in the action plan the individual responsible for each maintenance service, the expected completion date, the method for completing the repair, the status of the repair, the date of completion, and how it will be maintained over time.
    3. Upon completing the action plan, please provide a copy to the inspector by email by July 14, 2025.
    4. Please ensure that the action plan does not contain any PI/PHI.
3. Ensure that management in the home, including the Administrator, Director of Clinical Care and Quality, IPAC lead, and Maintenance Manager, actively participate in the development and implementation of the action plan.
4. Conduct a review of the preventive maintenance program to ensure it includes monthly audits verifying that maintenance in the home and its furnishings are kept in a state of good repair. Keep a record of the review, including the participants, the date of the review, and any changes made to the program.
5. Keep a record of all documents including quotes, contracts, preventative maintenance program records, and the action plan and make them available to inspectors upon request.

Grounds

The licensee has failed to ensure maintenance services in the home are maintained in good repair.

During a tour of the home, multiple resident home areas required maintenance, including light fixtures, windows, uneven flooring, damages to toilets, baseboards and walls in resident washrooms and bedrooms. When speaking with the home's Administrator, they indicated they were aware of some of the areas requiring repairs such as roofing, downspouts, and repainting, however, were not able to provide any insight to plans to make the repairs.

Failure to maintain the home in safe condition and good repair places residents at risk of physical injuries but also of microorganisms breeding due to water damage and poorly maintained environment.

Sources:

Observations and interview with staff.

This order must be complied with by

July 14, 2025

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #002 Construction, renovation, etc., of homes

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 356 (3)

Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:

1. Alterations, additions or renovations to the home.

2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1.The home will establish a Multidisciplinary Team (MDT) with expertise in infection prevention and control, direct patient care, risk management, facility design,

construction, and ventilation to create and implement the policy. The MDT shall include, at a minimum: IPAC Lead, Administrator, Maintenance Manager, and Clinical Management staff.

2. The home shall develop and implement a comprehensive policy and procedure for home maintenance, including assessments of both the interior and exterior of the home.

3. The IPAC Lead and designate with expertise in Construction, Renovation, Maintenance and Design (CRMD), will provide in person education and training related to CRMD to the members of MDT. Where appropriate, the IPAC Hub, may be considered to support the delivery of this training. The training shall include education on the requirements related to:

a. the regulatory requirements associated with different types of maintenance work;

b. definitions related to the type of maintenance work that requires prior approval;

c. Ministry of Long Term Care notification requirements when planning to conduct any type of maintenance work within their Long Term Care Homes; and

d. submission requirements for review, timelines for review, and the review process

4. Documentation of education must include:

a. First and last name of person providing education.

b. Contents of the education that was provided.

c. Name of staff educated and their signatures.

d. Date when the education was provided.

5. These records are to be produced upon Inspector request.

Grounds

A complaint was submitted to the Director raising concerns regarding waste management at the home and the overall condition of the home. Concerns were raised with regards to structural integrity and maintenance. During the inspection, the inspector inquired about the maintenance records as a part of the complaint follow up. The inspector observed new flooring in the dining room and activity room.

The Administrator, IPAC Lead, and Maintenance Manager confirmed that work was completed without obtaining the Director's approval prior to commencement of the project. The projects took place February 3, 2025, April 8-10, 2025, April 15-20, 2025.

Failure to obtain approval from the Director before commencing construction can lead to significant hazards within the home creating a potential safety risk for residents.

Sources: Observations and interview with staff.

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

This order must be complied with by September 9, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.