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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: May 15, 2025
Inspection Number: 2025-1003-0003
Inspection Type: Critical Incident
Licensee: King Nursing Home Limited
Long Term Care Home and City: King Nursing Home, Bolton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-15, 2025

The following intake(s) were inspected:

- Intake: #00140193: related to a resident fall

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques after a resident had a fall. A resident was displaying signs of injury while on the floor, but was assisted manually off the floor, instead of with the appropriate transferring technique as required, placing them at risk for further injury.

Sources: Resident's clinical records, the home's falls prevention and management policy, staff interviews