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: July 31, 2026
Inspection Number: 2026-1048-0005
Inspection Type: Proactive Compliance Inspection
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): July 15-17, 20-24, 27-31, 2026

The following intake(s) were inspected:
-An intake related to a Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

An initial tour of the home identified two resident rooms with sliding windows that opened to the outdoors, were accessible to residents, had a screen and could be fully opened more than 15 centimetres (cm).

The windows were previously secured not to open greater than 15 cm, the screw securing the windows was removed.

The Administrator and Maintenance staff confirmed the screws were removed when the external and internal window cleaning was completed and the screws were not re-installed.

Maintenance re-installed a safety screw to prevent windows from opening more than 15 cm when it was brought to their attention at the time of the observation.

Sources: Observations, interview with Maintenance and Administrator.

Date Remedy Implemented: July 15, 2026

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's

specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

A Housekeeper stated they completed testing of a cleaning and disinfection product as per the manufacturer's specifications but was unable to provide documented results for a specified period, as they did not record the results.

The home posted a new document for recording the daily testing of the chemical solution completed by staff.

Sources: Chemical testing procedure, interviews with a Housekeeper and Administrator.

Date Remedy Implemented: July 17, 2026

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1. Provision of the Point of Care (POC) tasks related to Activities of Daily Living (ADLs), were not documented for a resident on several dates. The Administrator acknowledged that the documentation was missing.

Sources: Clinical records for a resident and interview with the home's Administrator.

2. Provision of the Point of Care (POC) tasks related to ADLs were not documented for another resident on two dates. The Administrator acknowledged that the documentation was missing.

Sources: Clinical records for a resident and interview with the home's Administrator.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The diet list utilized by the Food Service Workers (FSWs) while cooking and serving the home's meals was not reviewed/revised to reflect a change to a resident's diet order. The diet list displayed the previous diet order.

Sources: Observation, clinical records for a resident, and interviews with a FSW, and the home's Registered Dietitian (RD).

WRITTEN NOTIFICATION: Screening measures

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 81 (2)
Screening measures
s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

A staff member was hired on a specific date. The Administrator confirmed that the home did not obtain a police record check for this staff member at the time of hiring or a receipt detailing that a police record check had been requested. The home did not obtain a police record check until a later date. The Administrator acknowledged that there was a gap in obtaining a police record check.

Sources: Employee file and interviews with the home's Administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 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,

An initial skin and wound assessment tool was not completed for a resident when they were exhibiting altered skin integrity.

Sources: Clinical records for a resident and interview with a Registered Nurse (RN).

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A resident was exhibiting altered skin integrity, however, the required weekly skin and wound assessment tool was not completed.

Sources: Clinical records for a resident and interview with a RN.

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the

staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The home's Spring/Summer 2026 menu cycle was not approved for nutritional adequacy by a RD who is a member of the staff of the home. The home's RD reported that the home purchases their menu cycles from an external company and that it is the responsibility of the RD's that work for the external company to ensure nutritional adequacy of the proposed menu cycle, not the RD of the home.

Sources: Interviews with the home's Food Services Manager (FSM) and the home's RD.

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

There was no written record of the evaluation required under clause (2) (b) related to the evaluation of the menu cycle.

Sources: Interviews with the home's FSM, the home's RD, and the home's Administrator.

WRITTEN NOTIFICATION: Menu planning

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and

available at each meal and snack. O. Reg. 246/22, s. 390 (1).

Planned menu items for lunch on a specific date, were not offered/available. A FSW indicated that the home was awaiting a food delivery, while the FSM reported that the home had the items and was unclear as to why they were not prepared/served.

Sources: Observation, Planned Menu Spring/Summer 2026, and interviews with a FSW and the home's FSM.

WRITTEN NOTIFICATION: Food production

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

Menu substitutions were not recorded on the production sheets. A planned menu item was reportedly substituted on lunch on a certain date. A FSW recorded the substitution on a food temperature log. The home's FSM indicated that the home does not record substitutions on the production sheets.

Sources: The home's food temperature logs, Audit Report of Dietary Services, Nutrition and Hydration, and interviews with a FSW and the FSM.

WRITTEN NOTIFICATION: Food production

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (8)
Food production
s. 78 (8) The licensee shall ensure that, during every hour in which a food service area is operating, there is at least one cook, food service worker or nutrition manager in the food service area who has successfully completed food handler training. O. Reg. 66/23, s. 16.

The home's food service areas are operated solely by FSWs, with a FSM only present

in the home on weekends. Based on the home's schedule, FSWs operate the home's food service areas independently and would be the only dietary staff present in the food service areas for certain hours during the weekdays. A FSW had a lapse in their food handler certification for a specified time frame. The safe food handler certificate for another FSW was expired at the time of the inspection. The safe food handler certificate for a separate FSW was expired prior to their date of hire.

Sources: Employee files and interview with the home's Administrator.

WRITTEN NOTIFICATION: Dining and snack service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

1. A resident required assistance for eating but did not receive the assistance from staff during the lunch meal service on a certain date, until the very end of the meal when dessert was being served.

Sources: Observation and clinical records for a resident.

2. Instructions in a resident's plan of care detailed that the resident required assistance for eating yet they did not receive assistance from staff during lunch on certain date.

Sources: Observation, clinical records for a resident, and interview with the Nurse Manager (NM).

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #014 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

During the Proactive Compliance Inspection (PCI), a resident was identified with respiratory symptoms indicating the presence of infection that were not monitored and recorded on every shift.

The IPAC Lead confirmed that registered staff are to monitor and document every shift on residents with symptoms of infection in the home's electronic documentation system and this was not completed every shift for the resident during an identified infection.

Sources: Outbreak Line Listing, clinical records for a resident, and interview with the IPAC Lead and Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

A review of the Long-Term Care Home’s (LTCH) Continuous Quality Improvement Committee (CQI) meeting minutes for a specific date, indicated that a Personal Support Worker (PSW) was not in attendance.

The Administrator confirmed that a PSW was not a member of the CQI committee.

Sources: CQI committee meeting minutes and interview with the Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

A review of the LTCH's CQI meeting minutes for a specific date, indicated that a representative of the Residents' Council (RC) was not in attendance.

The Administrator confirmed that a RC representative was not a member of the CQI committee.

Sources: CQI committee meeting minutes, interviews with a resident, and the Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

A review of the LTCH's CQI meeting minutes for a specific date, indicated that a Family Council (FC) representative was not in attendance.

The Administrator confirmed that a FC representative was not a member of the CQI committee.

Sources: CQI committee meeting minutes, interviews with a Substitute Decision Maker (SDM) and the Administrator.

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The home's management, nursing department, and registered dietitian will collaborate to develop and implement a system to monitor and evaluate the food and fluid intake of all residents with identified risks related to nutrition and hydration. As part of the development of this process, the home is to review and analyze the food and fluid requirements for the residents.
2. Provide education to all registered nursing staff on the system developed as per part one of this Compliance Order (CO). The home shall produce a list of the registered nursing staff required to complete the education. Education documentation must include: the date the education was provided, the full names and designations of educators and participants, confirmation that each registered nursing staff completed the education (e.g. attendance record, completion acknowledgement), and the contents of the education. Documentation must be retained and provided to the inspector upon request.
3. The home will conduct weekly audits for three consecutive weeks of all residents with identified nutrition risks to ensure that the developed system is implemented as expected. Documentation of the audits must include the date of the audit, the name and designation of the auditor, the name of the residents included in the audit, and any corrective actions when the home's system was not followed. This documentation must be retained and provided to the inspector upon request.

Grounds

The home did not have a system in place to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration. PSW staff were expected to record the food and fluid intake of each resident at meals, however, there was no system in place for the nursing staff or the home's RD to monitor or evaluate the recorded intake levels on a regular basis.

Without having a system in place to monitor and evaluate the food/fluid intake of residents with identified risks related to nutrition/hydration, there is risk that decreased food/fluid intake was not properly identified or addressed in a timely manner.

Sources: The home's resident list of nutritional risk, the home's policy related to the Nutrition and Hydration Program, electronic mail (e-mail) communication with the home's Administrator, and interviews with the home's RD, Nurse Manager, and the Administrator.

This order must be complied with by October 26, 2026

COMPLIANCE ORDER CO #002 Cooks

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 82 (1)
Cooks
s. 82 (1) Every licensee of a long-term care home shall ensure that there is at least one cook who works at least 35 hours per week in that position on site at the home. O. Reg. 246/22, s. 82 (1).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 82 (1) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:The home shall prepare, submit, and implement a plan to ensure that there is at least one Cook who has the requirements identified under O. Reg. 246/22, s. 82, who works at least 35 hours per week in that position on site at the home.

Please submit the written plan for achieving compliance for inspection #2026-1048-0005 to the inspector by e-mail, by August 28, 2026.
Please ensure that the submitted written plan does not contain any Personal

Information (PI)/Personal Health Information (PHI).

Grounds

The home does not have a dedicated cook that works at least 35 hours per week in that position on site at the home. The home's dietary department is composed of Food Service Workers (FSWs) that also fulfill the duties of the position of Cook. The home's Food Services Manager (FSM) acknowledged that the home does not have a Cook and that the FSWs do not have chef training or culinary management diplomas. The home's Administrator acknowledged that hours worked in the dual role of FSW/Cook do not count towards both positions. The home was unable to demonstrate that there is at least one Cook who works the minimum required hours per week in the position at the home.

Without a dedicated cook working at least 35 hours per week in that position at the home, there is increased risk of inconsistency in meal preparation, food safety risks, reduced oversight of food production, a potential decrease in nutrition/quality of meals, and resident dining experience.

Sources: Dietary Department Schedule, Employee Files, and interviews with a FSW, the home's FSM, and the Administrator.

This order must be complied with by October 26, 2026

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.