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**
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Waterloo, ON, N2V 1K8
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# Public Report

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| **Report Issue Date:** July 10, 2025 |
| **Inspection Number:** 2025-1495-0004 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Knollcrest Lodge |
| **Long Term Care Home and City:** Knollcrest Lodge, Milverton |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8, 9 and 10, 2025.
The following intake(s) were inspected:

- Intake: #00145442, related to infection prevention and control.

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

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 on every shift, three residents' symptoms indicating the presence of infection were monitored in accordance with any standard or protocol issued by the Director.

**Sources:** Residents' clinical records and interview with the IPAC Lead.

## 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 a respiratory outbreak that was declared by the Public Health Unit. The home submitted a Critical Incident (CIS) report to the Director two days later.

**Sources:** Home's CIS and interview with the IPAC Lead.