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

London District
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Original Public Report

Report Issue Date: February 1, 2023	
Inspection Number: 2023-1495-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Knollcrest Lodge	
Long Term Care Home and City: Knollcrest Lodge, Milverton	
Lead Inspector Cheryl McFadden (745)	**Inspector Digital Signature** Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2023.02.02 13:32:47 -05'00'
Additional Inspector(s) NA	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 18, 19, 20, 23 and 25, 2023

The following intake(s) were inspected:

- Intake: #00016267/Complaint IL-08420-LO related to improper/incompetent care of a resident
- Intake: #00017187/Critical Incident #2996-000009-22 related to the Fall Prevention and Management Program

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

- Resident Care and Support Services
- Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting re Critical Incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee failed to ensure that the Director was immediately informed of the unexpected or sudden death of a resident.

Rationale and Summary:
A Critical Incident (CI) Report documented a resident had fallen with a negative medical outcome.

Registered Practical Nurse and a Registered Nurse stated the resident had fallen with a negative medical outcome and the manager on call had been notified immediately.

Director of Care and the Executive Director stated they were aware of reporting requirements to the Director and they did not immediately notify the Director of this incident.

Sources: Critical Incident Report, health records for the resident, and interviews with staff.
[745]