Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: December 12, 2024
Inspection Number: 2024-1495-0004
Inspection Type: 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): November 6-8, 12-13, 2024
The inspection occurred offsite on the following date(s): November 14-15, 18, 2024

The following intake(s) were inspected:

- Intake: #00122961 - [CI: 2996-000012-24] - related to fall with injury
- Intake: #00125858 - [IL-0130782-AH/ CI: 2996-000014-24] - related to resident to resident physical abuse

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 licensee failed to ensure that a resident's plan of care was reviewed and revised when they were reassessed, and their care needs changed.

Rationale and Summary
A resident was assessed to be a risk for falls.

Staff discussed fall prevention strategies that would be appropriate for the resident, including safe transfers for the resident. The discussed interventions were not utilized causing the resident to fall. The Director of Resident Care stated that fall interventions could have been implemented to prevent further falls from occurring.

Failing to review and revise a resident's plan of care after being deemed a risk for falls, resulted in the resident having a fall causing injuries and a significant change in status.

Sources: interviews with staff and record review of a resident's clinical records.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that staff followed the home's Fall Prevention and Management policy following a resident's multiple falls.

As per O. reg., 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Fall Prevention and Management policy stated that after a resident has two falls in 72 hours, a falls risk assessment is to be completed and residents who are high risk are to be on the falling star program. The policy also states that after a resident has fallen, registered staff are to complete a huddle with staff to discuss possible contributing and preventive factors and document using the appropriate Fall reports. This information is to be utilized to collaborate with the interdisciplinary team to analyze the fall and minimize or eliminate contributing factors to prevent reoccurrence.

Rationale and Summary
A resident had a fall. Following the fall, no huddle was completed with staff to discuss potential interventions to prevent reoccurrence.

The resident had another fall within a short period of time. Following the fall, no huddle was completed with staff to discuss potential interventions to prevent

reoccurrence. Following the second fall, a falls risk assessment was completed, which identified the resident to be a high risk for falls.

The resident experienced another fall within another short period of time, which resulted in injury. A fall intervention was not implemented for the resident until after their third fall.

By failing to follow the home's Fall Prevention and Management policy, further interventions were not discussed and put in place for the resident.

Sources: interviews with staff, and record review of a resident's clinical records and the home's Fall Prevention and Management policy, revised August 16, 2024.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies that were developed to manage responsive behaviours for two residents, were implemented.

Rationale and Summary
A resident struck another resident after becoming agitated when they couldn't open a door.

Interventions were implemented to address the behaviours of the resident who initiated the striking.

At a later day, the intervention was not in place, and the resident struck the same resident again after entering their room.

A new intervention was implemented to prevent the resident from entering the same resident's room.

During the inspection, it was observed that the new intervention was not in place multiple times.

By failing to implement the residents' plan of care related to responsive behaviours, there was a risk of further altercations occurring between the two residents.

Sources: interviews with a resident and staff, observations of a resident's room, and record review of residents' clinical records

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director, was implemented.

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According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 7.3 (b) directs the licensee to ensure that audits are performed at least quarterly to ensure that all staff can perform the IPAC skills required for their role.

Rationale and Summary
From July to September, 2024, no audits were completed for the dietary department to ensure they could perform the IPAC skills required for their role.

The home was in a COVID-19 outbreak in September, 2024.

By failing to follow the IPAC Standard and not completing audits for all staff within the home at least quarterly to ensure they could perform the required IPAC skills for their role, there was risk of transmission of infectious agents.

Sources: interviews with the IPAC Lead and Food Service Manager and record review of the Hand Hygiene and Personal Protective Equipment (PPE) audits completed from July to September, 2024, and the IPAC Standard for LTCHs, dated April 2022.