Ontario



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

Ottawa District
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# Amended Public Report Cover Sheet (A1)

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| Amended Report Issue Date: July 19, 2024 |
| Original Report Issue Date: April 29, 2024 |
| Inspection Number: 2024-1551-0001 (A1) |
| Inspection Type:<br>Complaint<br>Critical Incident<br>Follow up |
| Licensee: Corporation of the City of Cornwall |
| Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall |

## AMENDED INSPECTION SUMMARY

This report has been amended to:
rescind NC #005 Written Notification and AMP related to FLTCA, 2021, s. 104 (4); and NC #008 Written Notification related to O. Reg. 246/22, s. 55 (2) (b) (iv). Please refer to inspection report #2024-1551-0003 where amended findings are issued.

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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22-23, 2024, Feb 26-29, 2024, March 1, 2024, March 4-8, 2024, and March 11-15, 2024.

The following intake was completed in this complaint inspection:

- Intake #00103049 was related to alleged abuse.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00097527/CI#M529-000053-23 was related to controlled substance missing/unaccounted.
- Intake #00102671/CI#M529-000064-23 was related to a missing resident, less than 3 hours.
- Intake #00102700/CI#M529-000065-23 was related to alleged neglect.
- Intake #00103452/CI#M529-000070-23 was related to improper treatment following a fall.
- Intake #00103619/CI#M529-000072-23 was related to falls prevention and management.
- Intake #00106275/CI#M529-000002-24 and Intake #00110169/M529-000016-24 involved the same resident and related to falls prevention and management.

The following intakes were completed in this Follow-Up (FU) inspection:

- Intake #00015538/Order #003 from Inspection #2022-1551-0002 was related to O. Reg. 79/10, s. 114 (3) (a) medication reconciliation.
- Intake #00100660/Order #001 from Inspection #2023-1551-0004 was related to FLTCA, 2021, s. 27 (1) (a) (ii) neglect.
- Intake #00100658/Order #002 from Inspection #2023-1551-0004 was related to O. Reg. 246/22, s. 55 (2) (b) (ii) skin and wound; and
- Intake #00100659/Order #003 from Inspection #2023-1551-0004 was related to O. Reg. 246/22, s. 55 (2) (b) (iv) skin and wound.

The following intakes were completed in this inspection: Intake #00102848, CI#M529-000069-23 was related to falls prevention and management.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2022-1551-0002 related to O. Reg. 79/10, s. 114 (3) (a).

Order #001 from Inspection #2023-1551-0004 related to FLTCA, 2021, s. 27 (1) (a) (ii).

The following previously issued Compliance Order(s) were found NOT to be in compliance:

Order #002 from Inspection #2023-1551-0004 related to O. Reg. 246/22, s. 55 (2) (b) (ii).

Order #003 from Inspection #2023-1551-0004 related to O. Reg. 246/22, s. 55 (2) (b) (iv).

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# AMENDED INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care related to falls prevention set out in the plan of care is provided to a resident as specified in the plan.

Rationale and Summary:
A resident was identified as a high risk for falls on a day in March 2024, as they have a history of a fall resulting in an injury, and forgetting to call staff for assistance with transferring and ambulation. According to their care plan on PointClickCare (PCC), the resident had multiple falls prevention interventions in place.

During an interview with staff, they confirmed that the resident requires multiple fall prevention interventions when they are in bed.

On March 11, 2024, Inspector observed the resident in bed sleeping. Two of the fall prevention interventions were not in place.

On March 11, 2024, staff observed the resident in bed and stated they were supposed to have several fall prevention interventions in place when in bed.

Not ensuring a resident's falls prevention interventions are in place can increase the risk that a resident sustains an injury from a fall.

Sources: Resident progress notes on PCC; resident care plan; observation by Inspector; and interviews with staff.

## WRITTEN NOTIFICATION: Documentation

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NC #002 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.

The licensee has failed to ensure that the documentation for the thirty minute safety checks for a resident was completed.

Rationale and Summary:
On a day in April 2023, a resident eloped from the home, and was found immediately outside of the front doors of the home. This resident's progress notes indicate they were placed on hourly safety checks at that time. On a day in November 2023, the resident eloped from the home for 15-30 minutes. The resident was redirected back into the home by a staff member with no injuries sustained. According to progress notes on PointClickCare (PCC), it was communicated to staff that the resident needed to be kept under observation and was increased to 30 minute safety checks.

Review of the 30 minute safety checks on Point of Care (POC) from December 2023, indicated that documentation was not completed for the resident on multiple dates.

During an interview with staff, they stated they often don't get to document the 30 minute safety checks due to time. During an interview with a supervisor, they confirmed that 30 minute safety check documentation should be completed and there should not be any gaps.

Failing to ensure increased checks are documented can increase the risk of

uncertainty whether the resident was checked or not.

Sources: Resident progress notes on PCC; 30 minute checks on POC for resident; and interviews with staff.

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that staff complied with the licensee's policy to promote zero tolerance of abuse.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a procedure in place for the reporting of allegations of abuse and must be complied with.

Specifically, staff did not comply with the licensee's policy #RC-02-01-02 - Zero Tolerance of Resident Abuse and Neglect Response and Reporting, last updated: January 2024, which was included in the licensee's Prevention of Abuse and Neglect Program.

Rationale and Summary
The licensee's policy #RC-02-01-02 stated that at a minimum, any individual who

witnesses or suspects abuse or neglect of a resident must notify management immediately, staff must notify their supervisor.

A review of the emails sent by staff to the management team to report two separate allegations of staff to resident abuse indicated that reporting was not immediate.

During an interview with staff, they stated that they had not immediately reported the allegations of staff to resident abuse to their supervisors.

By not immediately reporting an allegation of abuse or neglect to the supervisor as directed in the licensee's policy, places the resident at potential risk for further abuse and delays the investigation.

Sources: Review of email records; Policy #RC-02-01-02 - Zero Tolerance of Resident Abuse and Neglect Response and Reporting, last updated: January 2024; and interviews with staff.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that two separate allegations of staff to resident

abuse were immediately reported to the Director.

Rationale and Summary
A review of emails sent to management from staff revealed allegations of two separate incidents of staff to resident abuse.

There were no Critical Incident Reports on the Ministry of Long-Term Care website (ltchomes.net) related to either allegation of staff to resident abuse.

During an interview with management on March 7, 2024, they stated that the complaints of alleged staff to resident abuse were not reported to the Director.

By not immediately reporting allegations of abuse or neglect to the Director, decreases the required transparency between the licensee and the Ministry of Long-Term Care, increasing the risk that further abuse within the home could go unanswered.

Sources: Review of email documentation; the Ministry of Long-Term Care website; and interviews with staff.

## WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their written policy related to falls prevention and management for a resident.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to falls prevention and management for a resident is complied with.

Specifically, staff did not comply with the home's Falls Prevention and Management policy (#RC-15-01-01, reviewed January 2024): for 72 hours post-fall, notify the physician/NP if there is a sudden change in vital signs and/or neurological assessment, or if the resident cannot be easily roused.

Rationale and Summary:
On a day in December 2023, a staff member heard a resident's fall prevention intervention and found them on the floor beside their bed. The resident sustained no injuries, but was initiated on head injury routine monitoring. On a day in December 2023, staff reported to the unit nurse that the resident was unresponsive in the dining area. The resident remained on head injury monitoring. The charge RN assessed the resident and noted a change in health status. On a day in December 2023, the physician was informed of the resident's health status, and advised that the resident be sent to the hospital. The resident's SDM declined a hospital transfer, requesting to focus on comfort measures.

Upon review of the home's investigation notes, an RPN reported to a Supervisor on a day in December 2023, that the physician was never informed of the resident's unresponsive episode that occurred on a day in December 2023. The investigation notes indicated that the charge RN who assessed the resident on a day in December 2023, stated they dialed the physician's number, but hung up before

connecting due to intervening on another issue. The investigation notes state there was no other attempt made to call the physician.

During an interview with the Supervisor, they confirmed that the charge RN did not follow the home's Falls Prevention and Management policy related to informing the physician when the resident was unresponsive within the 72 hour post-fall time period. They stated it is the expectation that the charge RN would notify the physician when the resident was unresponsive, or delegate to the nurse working on the unit, but there was no indication that they delegated this task.

By not ensuring the written policy related to falls prevention and management was complied with and notifying the physician when the resident had a sudden change in their neurological condition within 72 hours post-fall, the resident was at an increased risk of harm.

Sources: Resident progress notes on PCC; the home's investigation notes; Falls Prevention and Management policy #RC-15-01-01; and interview with staff.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, a post-fall

assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary:
On a day in December 2023, a resident sustained a fall and was found by staff. According to the progress notes, the resident sustained an injury. The resident was restless and an RN was unable to complete a detailed assessment and vital signs. The resident's substitute decision maker suggested the resident be sent to hospital for further assessment. The resident left the home via ambulance.

Upon review of the resident's head injury routine, which was initiated on a day in December 2023, by an RN, a blank two page document titled "Falls Prevention Audit Tool" was attached.

In an interview with an RN, they stated the Falls Prevention Audit Tool is to be completed after every fall by the nurse in collaboration with the PSW's, and includes gathering information about what led to the fall, any potential unmet needs of the resident, and fall prevention strategies, including altering the care plan as needed.

In an interview with an RN, they stated they sent the resident to the hospital that morning and couldn't remember if they had completed the tool. The RN confirmed that the Falls Prevention Audit Tool is to be completed after every fall.

In an interview with a supervisor, they confirmed that the Falls Prevention Audit Tool should have been completed for the resident in this instance.

By not ensuring a Post Fall Audit Tool is completed after a fall, fall prevention strategies may not be assessed and can result in further falls or injuries to the

resident.

Sources: Resident progress notes on PCC; resident head injury routine and Falls Prevention Audit Tool; and interviews with staff.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to a complainant, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
There were no records to indicate that the licensee's responses made to the complainant related to complaints of alleged staff to resident abuse included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

During an interview with management, they stated that their processes in dealing with complaints had gaps at the time.

Sources: Review of emails; and interviews with staff.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to a resident, for which the resident was taken to hospital and resulted in a significant change in their health condition.

Rationale and Summary:
On a day in December 2023, a resident sustained a fall. According to the progress notes, the resident sustained an injury. The resident was restless and an RN was unable to complete a detailed assessment and vital signs. The residents substitute decision maker suggested the resident be sent to hospital for further assessment. The resident left the home via ambulance and later returned from the hospital with a change in their health status.

The Director was informed of this critical incident on a day in December 2023.

In an interview with a supervisor, they confirmed that this critical incident was reported late to the Director, and should have been reported within one business day for an incident that causes injury to a resident and results in a significant status change. They confirmed that the home would have been aware there was a significant status change of the resident several days prior to when the incident was reported.

Failing to notify the Director within one business day of an incident causing an injury to a resident resulting in a significant change to their health condition may prevent timely follow up.

Sources: Resident progress notes on PCC; and interview with staff.

## WRITTEN NOTIFICATION: Medication management system

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with their written policy related to medication management for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that

their written policy related to medication management for a resident is complied with.

Specifically, staff did not comply with the home's pharmacy Policies and Procedures: Manual for Medisystem Serviced Homes (December 2023) related to telephone orders, initiating medications administered under eMAR, inputting medication into eMAR, and wasting of narcotics.

Rationale and Summary:
On a day in September 2023, a resident's SDM spoke with a supervisor related to initiating care measures and having medications available as needed for the resident. According to progress notes, the charge RN informed the physician of this request, and there were orders obtained.

The Order sheet indicated the telephone order was taken by the charge RN and faxed to the pharmacy on a day in September 2023. There was no information on the order sheet as to which physician the order was obtained from and the date the order was obtained.

On another day in September 2023, the resident was demonstrating increased signs of pain and distress. A supervisor updated the physician and new orders were obtained for pain control.

The Order sheet indicated the telephone order was taken by a supervisor for the physician on a day in September 2023.

The orders obtained on both days in September 2023 did not have a physician's signature on either forms.

According to the Medisystem Policies and Procedures manual related to telephone orders, the orders must be dated and signed with both the nurse's and prescriber's name. The prescriber will authenticate these orders at their next visit or at the earliest opportunity.

In an interview with a supervisor, they confirmed that the physician is to sign the order sheet when they come in weekly for doctor's rounds, and both orders should have a physician's signature. They also confirmed that the order obtained on a day in September 2023, should indicate who the order was obtained from and the date the order was obtained. They confirmed this was not following the Medisystem policy.

According to the progress notes, the new orders obtained on a day in September 2023, were faxed to pharmacy at this time. The new order was not input into the resident's eMAR until the next day.

In an interview with an RPN, they stated that new medication orders are input by the pharmacy and nurses do not enter new orders into the eMAR. They stated if the order is not yet in the eMAR and the new order is due to be administered, they will write a progress note in PCC to ensure they document that the medication was given.

Review of resident's progress notes indicated that nurses were documenting that they were administering the new routine order.

According to the Medisystem Policies and Procedures manual related to inputting medication into the eMAR, if nursing is able to administer the new dose with medication on hand, then the new dose should be implemented immediately in the next administration time and a new order must be entered into the eMAR by nursing

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for administration. The manual also states that the eMAR is to be initialed for each medication given.

In an interview with the Clinical Consultant Pharmacist, they stated nurses are able to input new orders into the eMAR themselves if not yet input by pharmacy. They also confirmed that any medication administered to a resident has to be documented in the eMAR.

According to the resident's eMAR, on a day in September 2023, an RPN administered a medication under the order of 0.25mL subcutaneously every two hours when needed. When comparing this to resident's Narcotic and Controlled Drug Administration Record on paper, the RPN documented that 0.5mL of the medication was administered. The RPN also initialed on the Narcotic and Controlled Drug Administration sheet that the leftover amount of 0.5mL for the doses administered earlier in the day were wasted. The section titled "witnessed by" was blank.

According to the Medisystems Policies and Procedures manual, entries for wasted doses must be filled in completely with an explanation and the signature of a witness on the Narcotic and Controlled Substances Administration Record.

In an interview with a supervisor, they stated that they informed the RPN of the new routine dose of medication for the resident on a day in September 2023 when the RPN arrived for their shift. They stated that the RPN administered the correct new routine dose of medication, but their documentation was incorrect, as the administration of the routine dose should not have been documented under the PRN dose in the eMAR. The same supervisor also confirmed that when wasting a narcotic, two nurses are required to complete this and stated the RPN did not follow this process.

Not ensuring that the medication management policy is complied with increases the risk that resident's medications may be administered incorrectly.

Sources: Resident progress notes; resident order sheet; resident Narcotic and Controlled Drug Administration Record; resident's eMAR; Policies and Procedures: Manual for Medisystem Serviced Homes, December 2023; and interviews with staff and Clinical Consultant Pharmacist.

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that a controlled substance was stored in a separate locked area within the locked medication cart.

Rationale and Summary:
On a day in September 2023, an RPN discovered two opened vials of a narcotic in the top drawer of the medication cart, with medication still in them.

During an interview with the RPN, they stated that the previous nurse on night shift did not inform them of these partially used vials of narcotic in the medication cart. They confirmed that these ampules were not being stored in a double locked box.

During an interview with a supervisor, they stated if the nurse on night shift was not able to waste the remaining controlled substance with a second nurse right away, the vials should have been kept in the locked box within the medication cart.

Not ensuring that controlled substances are stored in a separate locked area within a medication cart increases the risk that a resident may be able to access these medications.

Sources: Medication incident report; and interviews with staff.

## COMPLIANCE ORDER CO #001 Plan of care

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Ensure a resident's falls prevention plan of care is reviewed and revised when care in the plan is not effective.

In ensuring the requirements under step 1 are met, the licensee shall:

2. Keep a written record of any revisions made to the resident's falls prevention plan of care, including evaluation of the effectiveness of interventions, and any corrective actions taken, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

3. Ensure that the plan of care related to falls prevention for the resident is followed by all staff.

In ensuring the requirements under step 3 are met, the licensee shall:
4. Develop and complete a weekly audit of staff compliance with the written plan of care related to falls prevention for the resident. This audit shall be completed for a period of four weeks. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings, and any corrective actions taken if deviations from the falls prevention plan of care are identified.

A written record must be kept of everything required under step (1), (2), (3), and (4) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that a resident was reassessed and their falls prevention plan of care reviewed and revised when the care set out in the plan has not been effective.

Rationale and Summary:
On a day in January 2024, a resident was found on the floor in their room. According to resident's care plan, they required one person to assist with transfers. An RPN assessed the resident and they were reporting discomfort, but adequate range of motion to all extremities and could weight bear. That evening the resident was

complaining of increased pain. The physician was notified and the resident was transferred to hospital for assessment. They sustained an injury and had surgery completed, returning from hospital at a later date. Resident now required two staff members for transferring assistance.

At the time of the fall, the resident's care plan related to falls prevention indicated they were at risk for falls and that they had an intervention in place for when in bed or seated in a chair.

According to the Falls Prevention Audit Tool completed by staff, on a day in January 2024, the resident had to use the washroom, removed the intervention, was confused and forgot to ring the call bell.

During an interview with staff, they confirmed that the resident required one person assistance for toileting at that time and stated the resident forgets to ring their call bell for assistance. They stated the resident is able to remove their fall prevention intervention.

On a day in February 2024, the resident was found on the floor in the washroom. The physician was notified and the resident was sent to hospital for assessment. The resident's discharge notes from the hospital indicate that they had an injury and required surgery to resolve this. On a day in March 2024, the resident returned from hospital.

According to the Falls Prevention Audit Tool completed by staff on a day in February 2024, the resident self-transferred without staff assistance because they forgot that they needed assistance and removed their intervention.

During an interview with staff, they stated they administered the resident's

medications 15 minutes before they fell. At this time, the resident was in their wheelchair and their fall prevention intervention was not in place. Staff stated they were unsure if resident had detached it from themselves, but they re-attached it at that time.

During an interview with staff, they stated that they were working the evening of a day in February 2024, and the resident's intervention was not working. They stated the resident had removed the intervention.

In an interview with the same staff member, they also stated that the resident detaches their intervention, stating the intervention most often doesn't work for the resident.

During an interview with management, they stated that specific fall prevention interventions are used for residents who are a fall risk. Management stated they were not aware that the resident frequently removes their intervention. They acknowledged that this would not be an effective falls prevention intervention and they should be looking at other ways to be alerted if the resident is trying to get up. They confirmed that if a fall intervention is not effective, they would collaborate with the team and come up with other interventions to trial. They confirmed that the staff should have done more with the information on the Falls Prevention Audits Tools from January to February 2024, related to the resident removing the intervention.

Not revising a resident's falls prevention plan of care when the plan is ineffective places the resident at risk of further falls and potential injury.

Sources: Resident progress notes on PCC; resident's care plan; Cornwall Community Hospital records for the resident; resident's Falls Prevention Audit Tools; and interviews with staff.

This order must be complied with by June 6, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Previous CO(HP) issued to FLTCA, 2021, s. 6 (10) c.
According to compliance history report, issued date is 2023-09-25 within Inspection #2023-1551-0003.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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## REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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.