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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 25, 2023	
Inspection Number: 2023-1148-0006	
Inspection Type: Follow up Critical Incident System	
Licensee: Sherwood Park Manor	
Long Term Care Home and City: Sherwood Park Manor, Brockville	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.08.01 14:24:58 -04'00'
Additional Inspector(s) Ashley Bernard-Demers (740787)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21 and 24, 2023

The following intake(s) were inspected:

- Intake: #00084820 - Follow-up #: 1 - FLTCA, 2021 - s. 28 (1) 2 - reporting to the Director.
- Intake: #00084821 - Follow-up #: 1 - O. Reg. 246/22 - s. 104 (1) (b) - notification of the substitute decision maker.
- Intake: #00084822 - Follow-up #: 1 - O. Reg. 246/22 - s. 123 (2) - medication administration.
- Intake: #00020624/CIS# 2640-000002-23 - regarding a choking incident.
- Intake: #00022424/CIS# 2640-000003-23 - regarding and unexpected death.
- Intake: #00022935/CIS# 2640-000004-23, Intake: #00087766 /CIS# 2640-000011-23 and Intake: #00084109/CIS #2640-000005-23 - regarding resident falls with injury requiring transfer to hospital.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #01 from Inspection #2023-1148-0005 related to FLTCA, 2021, s. 28 (1) 2. inspected by Wendy Brown (602)
Order #02 from Inspection #2023-1148-0005 related to O. Reg. 246/22, s. 104 (1) (b) inspected by Wendy Brown (602)
Order #03 from Inspection #2023-1148-0005 related to O. Reg. 246/22, s. 123 (2) inspected by Wendy Brown (602)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
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 (7)

The licensee failed to ensure that a resident was provided with the appropriate diet texture.

Rationale and Summary:
A resident's diet orders and care plan indicated they were to receive a minced texture diet. The resident was provided a peanut butter sandwich, which resulted in a choking incident. Interviews with two staff confirmed that the sandwich had a crust which is to be avoided on a minced diet. The Registered Dietitian updated the resident's diet order and care plan following the incident indicating they were to continue with a minced diet (no crust) and they were no longer allowed peanut butter.
Several weeks later a progress note indicated that the resident was provided snacks; specifically listing peanut butter as one of the snacks provided.

A resident required a minced texture diet and was not to be provided peanut butter. The risk of not receiving the proper diet placed the resident at risk for choking.

Sources:
Resident's diet order, care plan, and progress notes; and interviews with two personal support worker staff. [740787]