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

Public Report

Report Issue Date: January 20, 2026
Inspection Number: 2025-1148-0006
Inspection Type: Critical Incident
Licensee: Sherwood Park Manor
Long Term Care Home and City: Sherwood Park Manor, Brockville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 15, 17, 18, 22, 23, 2025 and January 8, 12, 13, 14, 16, 19, 20, 2026

The following intake(s) were inspected:

- Intake: #00162673-CIR 2640-000043-25, Intake: #00162699-CIR 2640-000044-25, Intake: #00163670-CIR 2640-000046-25, Intake: #00163956-CIR 2640-000047-25-Fall of a resident resulting in an injury and transfer to hospital.
- Intake: #00166055-CIR 2640-000051-25-Unexpected death of a resident.

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

Resident Care and Support Services
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 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A. The written plan of care for a resident did not set out the planned care that the resident was to be toileted. The plan of care noted that the resident was to use a bed pan in bed but they were being toileted by staff.

Sources: Resident's medical records and interviews with the Rehab Services Manager and a Personal Support Worker (PSW).

B. The written plan of care for a resident did not set out the planned care that the resident was to be transferred from the transport chair to bed or their lounge chair after meals as a fall intervention.

Sources: Resident's medical records and interviews with the Rehab Services Manager and a PSW.

WRITTEN NOTIFICATION: Documentation

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 provision of care set out in the plan of care for toileting and continence for a resident was not documented in Point of Care (POC) on numerous dates and shifts in November, 2025.

Sources-Resident's medical records.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's Lifting/Transferring Nursing Policy was not evaluated and updated at least annually as the last revision date was April 2021.

Sources-Lifting/Transferring Nursing Policy R-655 and interview with the Director of Care.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specific date in January, 2026, a resident was observed to be transferred using a mechanical lift with only one PSW present. As per the home's Lifting/Transferring Nursing Policy, two staff members must be present when using a mechanical lift to transfer a resident.

Sources: Observation of a resident, the home's Lifting/Transferring Nursing Policy R-655 and interviews with a PSW and the Director of Care (DOC).

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 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.

A resident sustained two falls in December 2025. Following these falls, post-fall

assessments were not conducted using a clinically appropriate instrument that is specifically designed for falls.

Sources: Review of a resident's Point Click Care (PCC) assessments and interviews with the Associate Director of Care (ADOC).

A resident sustained a fall on a specific date in November, 2025. Following this fall, a post-fall assessment was not conducted using a clinically appropriate instrument that is specifically designed for falls.

Sources: Review of a resident's PCC assessments and interviews with a Registered Nurse (RN) and the ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
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):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

An immediate report to the Director did not occur for a resident's death, which occurred on a specific date in December, 2025, and was deemed unexpected by the home. This unexpected death was not reported to the Director until several days later.

Sources: Review of the Critical Incident System (CIS) Report and review of the resident's progress notes.

COMPLIANCE ORDER CO #001 Falls Prevention and Management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Re-educate the two Personal Support Worker's (PSW's) involved on the care planned interventions to mitigate the risk of falls for a resident and the importance of reporting a change in condition of a resident to the registered nursing staff.
B) Re-educate all nursing staff including the two PSW's, the Registered Practical Nurse (RPN) and the Registered Nurse (RN) involved on the requirements of the home's Falls Prevention Program including the definition of a fall.
C) Maintain a written record of the contents of the education provided from part A) and B) of this order, the dates the education was provided, name of the attendees, their signatures and the individual(s) that provided the training until the MLTC has deemed that this order has been complied with.

Grounds

On a specific date in November, 2025, a resident sustained an unwitnessed fall and four staff members did not comply with the home's Falls Prevention Program. As per O. Reg 246/22 s. 11 (1) b., the home must have a falls prevention and management program, and that program must be complied with.

The home's Falls Prevention Program defined a witnessed or unwitnessed fall as any unintentional change in position coming to rest on the ground or onto the next lower surface but not as a result of an overwhelming external force. The policy requirement when a resident has fallen is the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs. The person witnessing the fall or finding the resident after the fall is to not move the resident until a full head to toe assessment has been completed by registered nursing staff and notify the charge Registered Nurse (RN) of the incident. Registered nursing staff are to complete a head to toe assessment after a resident fall, provide immediate first aid if required and if there is suspicion or evidence of an injury contact 911 to transfer to hospital. Without evidence of injury, move the resident ensuring the proper lifting procedures are performed (2 person lift if the resident is able to weight bear, otherwise a 2 person mechanical lift). Observe for pain or difficulty weight bearing and notify the attending physician, Power of Attorney (POA)/Substitute Decision Maker (SDM) of the fall, interventions taken and the status of the resident. Registered staff are to check vital signs and neuro vital signs if the fall was unwitnessed, complete an incident report under Risk Management, monitor the resident with frequent safety checks, carry out interventions to prevent recurrence, monitor for any change in condition and provide comfort to the resident. Determine if restrictions to mobility are warranted, determine circumstances leading to the fall (cause of fall) and meet with interdisciplinary team to prevent recurrence, revise the Fall Risk Screening,

Assessment and Management Tool if required, review the falls prevention interventions and modify the plan of care in collaboration with the interdisciplinary team. Communicate to all shifts that the resident has fallen and share details regarding the interventions initiated, emphasize the details of the fall, interventions and outcomes and stress the need for ongoing follow-up in subsequent shifts at shift report. The Falls Prevention Program also noted Standard Fall Prevention interventions are implemented for all residents and additional interventions for those at high risk for falls such as bed and/or chair alarm devices, commode/bedpan at the bedside, as required and for Personal Support Workers (PSWs) to follow the falls prevention strategies as outlined on the kardex.

Specifically, on a specific date in November, 2025 a resident was ambulated using a walker by two PSW's to a lounge chair in the common area. The resident was to have fall interventions in place which were not applied or accessible. A short time later, the resident was found on the floor in front of the lounge chair by a PSW. The PSW attempted to lift the resident off of the floor on two occasions but was unable. The PSW then requested the help of a Registered Practical Nurse (RPN) to assist with lifting the resident off of the floor. The RPN did not conduct an assessment of the resident prior to lifting them from the floor and stated that the resident was grimacing when standing. The RPN then informed a Registered Nurse (RN) that the resident had slid off of the chair. The RN did not conduct an assessment of the resident as they determined that this did not meet the definition of a fall. The two PSW's then attempted to ambulate the resident to the dining room for supper but the resident was unable to weight bear so the PSW's placed the resident in a wheelchair and transported them to the dining room. The two PSW 's did not report this change in condition of the resident to the registered staff. The following day, a PSW reported to the Director of Care (DOC) that the resident was having decreased weight bearing and was complaining of pain. The DOC assessed the resident with the Rehab Services Manager and sent them out to hospital for assessment of a

suspected injury. The Rehab Services Manager then reviewed the video footage and found that the resident had sustained a fall when they had attempted to stand and ambulate without access to their mobility device. During interviews with the DOC and the Associate Director of Care (ADOC), it was confirmed that two PSW's, an RPN and an RN did not follow the home's Falls Prevention Program, the required assessments and documentation were not completed for the resident when they fell and the resident did not have their fall interventions in place at the time of the fall.

Sources: Resident's medical records, the home's investigation file, Critical Incident Report (CIR) 2640-000046-25, Falls Prevention Program Updated April 2025 and interviews with the DOC and ADOC.

This order must be complied with by March 20, 2026

REVIEW/APPEAL INFORMATION

TAKE NOTICE The 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

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.