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

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Public Report

Report Issue Date: April 10, 2025
Inspection Number: 2025-1148-0002
Inspection Type: Complaint Critical Incident
Licensee: Sherwood Park Manor
Long Term Care Home and City: Sherwood Park Manor, Brockville

INSPECTION SUMMARY

The inspection occurred on site on the following dates: April 4, 2025, April 7-10, 2025.

The following intake was completed in this Critical Incident (CI) inspection:
Intake #00143133/ CI#2640-000010-25 was related to a fall sustained by a resident that resulted in a significant change, requiring a transfer to the hospital for treatment.

The following intakes were completed in this complaint inspection:
Intake #00142943 was related to concerns regarding falls prevention and post fall management for a resident.

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

Skin and Wound Prevention and Management
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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a specific resident's substitute decision maker (SDM) was given an opportunity to participate in the development and implementation of the resident's plan of care after the resident sustained a fall on a specific date.

Sources: resident's health care records and interview with a specific staff member, Fall Prevention Policy and Procedure (revised April 2024)

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.

1) The licensee has failed to ensure that provision of care set out in the plan of care for a specific resident was documented. Specifically related to monitoring of the

resident every two hours for safety due to their risk of falls. A review of the resident's Point of Care documentation during a specific month reflected no documentation was completed for the month.

Sources: the resident's care plan (revised January 9, 2025, Point of Care documentation during a specific month, interview with a specific staff member.

2) The licensee has failed to ensure that provision of care set out in the plan of care for a specific resident was documented. Specifically related to monitoring of the resident every two hours for safety due to their risk of falls. A review of the resident's Point of Care documentation during a specific month reflected no documentation was completed for the month.

Sources: Point of Care Documentation during a specific month, the resident's care plan, interviews with five specific staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a specific resident received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for

skin and wound assessment.

On a specific date the resident sustained a new skin impairment. During an interview with a specific staff member they indicted a dressing was applied to the area, however they did not complete an assessment of the skin impairment using a clinically appropriate tool.

Sources: the resident's progress notes, interview with a specific staff member.