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**
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# Original Public Report

**Report Issue Date:** October 30, 2023

**Inspection Number:** 2023-1145-0003

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

**Long Term Care Home and City:** Stoneridge Manor, Carleton Place

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Anandraj Natarajan (573) | Anandraj (Andy) Natarajan Digitally signed by Anandraj (Andy) Natarajan Date: 2023.10.30 16:03:55 -04'00' |

**Additional Inspector(s)**
Laurie Marshall (742466)
Lisa Kluke (000725)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 27, 28, 2023, October 3, 4, 5, 6, 10, 11, 12, 13, and 16, 2023.

The following intake(s) were inspected:
Intake: #00090025 - Complaint related to refusal to accept the applicant for admission.
Intake(s): #00092819 and #00095723 – Complaints /concerns related to care and services to the residents.
Intake(s): #00084910, #00085718, #00089664 and #00092227 – Allegation of resident-to-resident sexual abuse.
Intake: #00084299 - Allegation of staff to resident emotional/verbal abuse.
Intake(s): #00089671 and #00092893 - Allegation of staff to resident emotional abuse.
Intake(s): #00093439 and #00096070 - Allegation of staff to resident neglect.
Intake: #00096900 - Fall of a resident resulting in an injury and transfer to the hospital.

The following intakes were completed in this inspection: Intake(s): #00015888, #00095074, #00096496, and #00098647 were related to falls.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

# INSPECTION RESULTS

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

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

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

**(I) Rationale and Summary:** Resident #005's plan of care, indicated that the resident required mechanical lift assistance by two staff members for transfer to bed and that they are to go to bed by specified hours in the night. The plan of care further indicated that the resident is dependent on continence care and needs to remain clean and dry for skin breakdown related concerns.

During an interview, resident #005 indicated that PSW #108 did not transfer them to bed before the end of their shift on a specified date and time. Resident #005 indicated that they were seated in their wheelchair for a specified period when PSW #109 and PSW #112 transferred the resident to their bed.

PSW #108 reported to the inspector that they were working on a specified date, and did not have time to transfer resident #005 to their bed before leaving for the night. PSW #109 reported they discovered

resident #005 seated in the wheelchair at their bedside, they and PSW #112 transferred resident #005 to bed and observed that the resident was heavily saturated. Additionally, PSW #109 indicated they were not made aware of resident #005 being left in their wheelchair at the change of evening to night shift report.

The Director of Care (DOC) indicated that based on the home's investigation, there was a miscommunication between the PSW and the Registered nursing staff. Resident #005's plan of care was not followed for the bed routine and continence care as specified by their plan. PSW staff failed to provide the care as specified in the resident's plan of care resulting in altered skin integrity.

**Sources:** Resident #005's health care records, interviews with resident #005, PSW #108, #109, and the Director of care. [000725]

**(II) Rationale and Summary:** The plan of care for resident #011's responsive behavior directed the staff to provide step-by-step instructions for the provision of all care. The plan of care indicated that if the resident was resistant to care the staff were to stop, leave, and re-approach.

During an interview, PSW #121 indicated that on a specified date, when resident #011 was resistant to care they failed to stop, leave, and re-approach the resident. Furthermore, they indicated that they continued with the care while the resident was exhibiting resistive behaviors. PSW #121 failure to follow resident #011's plan of care could trigger their responsive behaviors and negatively affect the resident's mental well-being.

**Sources:** Resident #011's health care records, and interview with PSW #121. [573]

## WRITTEN NOTIFICATION: Documentation

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #006.

**Rationale and Summary:** The plan of care for resident #006 directed the staff to provide the resident's bath twice a week. A review of resident #006's bath record indicated that they did not receive four of their scheduled baths in June, seven baths in July, and one bath in August 2023. There was no documentation by the PSW staff that resident #006 received their bath for the specified days in June,

July, and August 2023.

During an interview, the ADOC indicated that the PSWs were expected to complete the residents' bath record documentation with the provision of care. The ADOC acknowledged that there was missing documentation to indicate that resident #006 received their bath on the identified dates in June, July, and August 2023. Failure to ensure that the care set out in the plan of care was documented could negatively impact resident #006's care.

**Sources:** Resident #006's plan of care, progress notes, bath records, and interview with the ADOC. [573]

## 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)

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse was complied with.

**(I) Rationale and Summary:** The licensee's policy related to Resident Non-Abuse ADMIN1-P10-ENT under the standard, indicated that "Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift".

The licensee submitted a Critical Incident Report regarding an allegation from PSW #116 of a witnessed incident of staff to resident verbal/ emotional abuse. This allegation was not reported by PSW #116 to the Executive Director of the home until five days after the incident.

PSW #116 indicated to the inspector that they observed PSW #115 yell at resident #008 while resident #008 was having responsive behaviors. PSW #116 indicated that Recreation Assistant #117 was trying to redirect resident #008 to their bedroom and indicated they heard PSW #115 yell at resident #008. PSW #116 further indicated they reported this incident to the Executive Director five days after the incident. An interview with Recreation Assistant #117 indicated to the inspector that they had observed PSW #115 raise their voice at resident #008 but had not reported this to anyone to date.

The Executive Director indicated during an interview with the inspector that PSW #116 and Recreation Assistant #117 did not follow the home's policy titled Resident Non-Abuse, regarding anyone who becomes aware of or suspects abuse of a resident must report immediately. PSW #116 and Recreation

Assistant #117 failed to immediately report an alleged, suspected staff to resident abuse for resident #008, which placed the residents at risk of harm.

**Sources:** Critical Incident Report, Policy for Resident Non-Abuse #ADMIN1-P10-ENT, interviews with PSW #116, Recreational Assistant #117 and the Executive Director. [000725]

**(II) Rationale and Summary:** The licensee submitted a Critical Incident report regarding an allegation from PSW #124 of an alleged staff to resident verbal abuse. This allegation was not reported by PSW #124 to the Executive Director until several days later after the incident. The Executive Director indicated during an interview with the inspector that PSW #124 did not follow the home's policy titled Resident Non-Abuse, regarding anyone who becomes aware of or suspects abuse or neglect of a resident must report that information immediately. PSW #124 failed to immediately report an alleged, suspected staff to-resident verbal abuse for resident #015, which placed the residents at risk of harm.

**Sources:** Critical Incident Report, Policy for Resident Non-Abuse #ADMIN1-P10-ENT, interview with the Executive Director. [000725]

**(III) Rationale and Summary:** The licensee's policy related to Resident Non-Abuse ADMIN1-P10-ENT under the standard indicated that "if there is any allegation towards a staff member, they will be suspended on administrative leave with pay immediately until an investigation is complete".

A Critical Incident Report was submitted to the Director regarding an alleged staff to resident #011 verbal and physical abuse incident. A record review indicated that the two PSW staff members involved in the incident were not placed on investigative leave immediately as per the home's Resident Non-Abuse policy. Furthermore, the PSW staff members were working until they were placed on investigative leave two days after the incident. In an interview, the ADOC acknowledged that the identified PSW staff members were working in the home until they were placed on the pending investigative leave two days after the incident. Failure of the licensee to follow the home's Resident Non-Abuse policy and the identified PSW staff members continuing to work in the home posed a potential risk of harm to the residents.

**Sources:** Critical Incident Report, Policy for Resident Non-Abuse ADMIN1-P10-ENT, resident #011's health care records, and interview with the ADOC. [573]

## WRITTEN NOTIFICATION: Licensee consideration and approval

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)

The licensee has failed to take into account and approve applicant #016's admission to the home based on the assessments and information that were provided to the home by the placement coordinator unless (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacks the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

**Rationale and Summary:** The inspector reviewed the licensee's written notice to withhold approval for applicant #016's admission to the home. Upon review, the written notice did not provide a reason for withholding approval of the applicant's application which met with the legislative reference related to FLTCA, 2021, s. 51 (7) (b).

The inspector spoke with the Resident Service Coordinator (RSC), who confirmed the contents of the written notice to applicant #016. Furthermore, they indicated that the staff of the home lack the nursing expertise necessary to meet the applicant's responsive behavior care needs. The RSC acknowledged that the licensee did have Psycho-geriatric services and Behavioural Support Ontario (BSO) staff to assist residents with responsive behaviors. The Inspector reviewed with the RSC that the licensee had access to High-Intensity Needs (HIN) funding from the Ministry of Long-Term Care wherein funds could be made available for staffing needs related to the care of a resident.

The inspector reviewed the written notice and the legislative requirements for withholding approval of an applicant for admission with the RSC. Upon review, the RSC was unable to provide sufficient information to validate the legislative rationale for the withholding approval of applicant #016's admission to Stoneridge Manor. The licensee's decision to withhold the applicant's admission to the home could potentially impact their physical and financial well-being.

**Sources:** The licensee's written notice to applicant #016, and interview with the RSC. [573]

## WRITTEN NOTIFICATION: Continence care and bowel management

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

The licensee has failed to ensure that resident #014, who is unable to toilet independently received assistance from staff to manage and maintain continence.

**Rationale and Summary:** A review of the Critical Incident Report (CIR) indicated that resident #014 rang their call bell for staff assistance with their continence care. Furthermore, it indicated that PSW #122 failed to assist the resident with the resident's continence care. Resident #014's health care record identified that the resident was frequently incontinent for bladder. The resident's plan of care indicated that they required staff assistance to manage their urinary incontinence. The resident's plan of care indicated that the resident required continence products to manage their continence and the PSW staff was to check the resident every two hours on the night shift.

During an interview, the DOC indicated that PSW #122 failed to check and assist resident #014 with their continence care needs when required. The PSW failed to assist with resident #014's continence care placing the resident at risk of not having their needs met as per their continence plan.

**Sources:** Critical Incident Report, resident #014's health care records, and interview with the DOC. [573]